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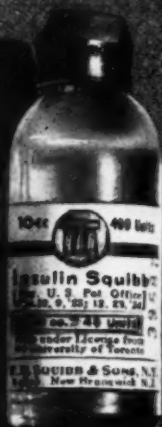
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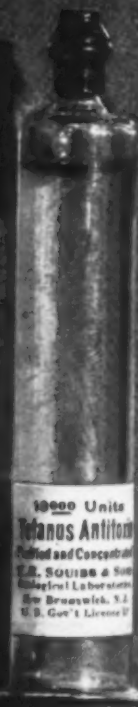


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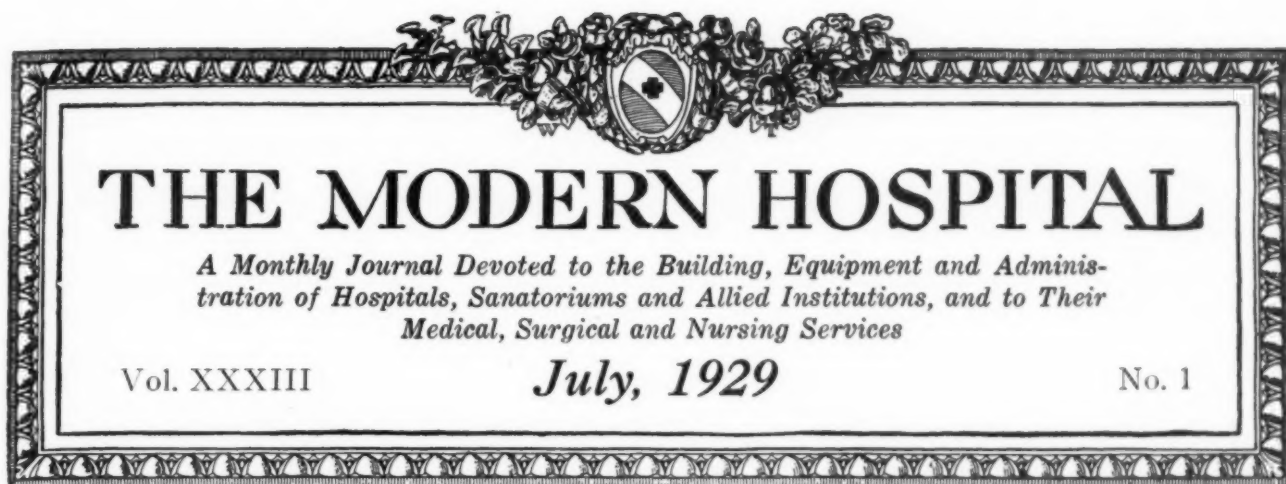
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# THE MODERN HOSPITAL

*A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services*

Vol. XXXIII

July, 1929

No. 1

## A. H. A. Accomplishments Reviewed in Presidential Address\*

By L. H. BURLINGHAM, M.D.

President, American Hospital Association

**M**EMBERS of the American Hospital Association, Members of the International Hospital Congress, Members of the Exhibitors' Association and Guests:

There are natural periods for celebration. A birthday is one. A second celebration is when one is made a voter on his or her twenty-first birthday. Those who are college graduates return to their Alma Mater for reunions, at three or five-year intervals after their graduation. We are all familiar with the various wedding anniversaries. Some celebrations are held because of the regular lapse of time, but there are others that are dignified by some extraordinary event.

Six years ago our hospital association convention celebrated the twenty-fifth anniversary of its birth. To-day the International Hospital Congress marks our thirty-first anniversary. On behalf of the officers and members of the American Hospital Association may I tell you, delegates and guests to the International Hospital Congress, how happy we are to have you here. It is an event that has been anticipated with keen pleasure. Much time and work have been expended in completing the plan and the details. We are glad that you could come. We trust that you have received benefit from your meetings and the observations you have made. We know that we shall profit by your presence and participation in our meeting.

It has been well said that "civilization may be

measured by the solidarity of mankind." What can contribute more to this solidarity than a meeting of outstanding representatives of more than forty countries, whose chief interest in life is the lofty one of benefiting the health of all humanity. No argument is needed as to the prime importance of health if one is to complete in the best possible way his destiny in this world.

At the twenty-fifth anniversary Asa S. Bacon, our perpetual secretary, at the unanimous request of our membership, took a year's vacation from that position to become our president, and wisely took as the subject of his presidential address a history of the American Hospital Association up to that time.

I wish to condense to a brief form the salient features of his address and the events since that time.

My object in giving a short sketch of the American Hospital Association is threefold. I am certain it will be of interest to those of our membership who were not present and did not hear Mr. Bacon's interesting address and I believe it may give our distinguished guests of the International Hospital Congress a background which may help them to understand better our organization and this convention.

My third reason is best illustrated by a figure of speech. This simile is taken from the sea and seems appropriate because we are meeting on the edge of the Atlantic Ocean. A ship starts for a given port and at regular intervals the mariner takes his bearings and then changes his course, if

\*Delivered at the thirty-first meeting of the American Hospital Association, Atlantic City, June 17, 1929.

necessary, to pursue his voyage to his appointed destination.

To translate this figure of speech into ordinary hospital language, it will be conceded by all hospital administrators that it is wise to take account of stock at regular intervals, figure up profit and loss and make out a budget.

Just how the association is to develop in detail cannot be predicted far in advance, but it is possible to set up as a general guiding principle the admirable and brief statement in the last sentence of Article 2 of our constitution, which deals with the object of our association and which ends, ". . . and in general to do all things which may best promote hospital efficiency."

#### *Superintendents Originate Association*

When we see this great concourse of persons in this hall it is difficult to believe that less than thirty-one years ago, to be exact, on September 12, 1899, this organization came into being as the Association of Hospital Superintendents, at a meeting in the Colonial Hotel in Cleveland, called by James S. Knowles, superintendent, Lakeside Hospital, Cleveland. The meeting was attended by eight superintendents. The superintendents came from four cities, Cleveland, Detroit, Ann Arbor and Pittsburgh.

At this, the thirty-first meeting of the American Hospital Association, we have registered 419 delegates from 304 hospitals in forty-one states and two provinces, 336 personal members, 773 guests and ninety-seven delegates from forty-one foreign countries. At the first meeting of the American Hospital Association there were just enough members to fill the offices and no more. Now we have all the offices that any well constituted organization finds desirable; a full-time executive secretary and ten sections, each with a chairman and secretary, six standing committees with twenty members and fifteen special committees with 106 members and four groups of delegates consisting of eight members.

1900—It is of great personal interest to us that Daniel D. Test and E. S. Gilmore, past presidents and trustees of our association, who have been of the highest value to the association during nearly its whole life, attended the second meeting.

1901—The first meeting to be attended by a person from outside the U. S. A. was the third convention at which Dr. Charles O'Reilly, superintendent, Toronto General Hospital, was present.

1902—The treasurer's report at the fourth meeting showed total receipts since the organization of the association of \$640, and expenditures of \$376, which is in sharp contrast to our present annual budget of \$75,000.

1903—At the fifth convention, a committee on uniform hospital accounts was appointed.

1904—The sixth was the first conference held in Atlantic City, with sixty-one persons registered, so that this is the twenty-fifth anniversary of our first meeting in Atlantic City. This meeting also saw the introduction of the question box or round table.

1905—Sir Henry Burdett of the *Hospital World*, London, read a paper at the seventh meeting and T. H. Heard, Victoria Hospital, London, was present.

1906—It is noteworthy that Asa S. Bacon attended the eighth meeting and was elected treasurer.

1907—At the ninth meeting the present name was adopted and committees similar to our present ones were appointed.

1908—The American Hospital Association first visited Canada for its tenth meeting and departmental sections were suggested.

1909—At the eleventh meeting associate membership, which had been established three years before, was extended.

1910—For the first time there was a noncommercial exhibit at the twelfth meeting and a round table for superintendents of small hospitals was held.

1911—The thirteenth had a session for hospital directors and trustees.

#### *Social Service Section Organized*

1912—Social service first appeared at the fourteenth conference. A motion for a permanent bureau of hospital information was adopted.

1913—Occupational therapy first appeared at the fifteenth meeting and section meetings were held and membership was enlarged to staff members and superintendents of nurses.

1914—A permanent secretary, an official organ and standardization of supplies were suggested at the sixteenth.

1915—A permanent secretary was voted at the seventeenth and a joint session with the American Nurses Association was held.

1916—A board of trustees and geographical sections were created at the eighteenth session, and the first commercial exhibit was held. A full-time secretary, Dr. William H. Walsh, was appointed between the eighteenth and nineteenth meetings.

1917—At the nineteenth meeting it was voted to incorporate, and the office of president-elect was created.

1918—Institutional membership was authorized and the sections idea was developed at the twentieth convention.

1919—The twenty-first meeting had a daily convention bulletin issued by *Hospital Management* and Howell Wright was the executive secretary.

1920—At the twenty-second session, Dr. A. R. Warner was the executive secretary, an office in Chicago was opened, geographical sections were established and two geographical sections were admitted. The American Hospital Association participated in the organization of the Hospital Library and Service Bureau.

1921—At the twenty-third meeting, the section on dietetics had its first program, and a report was made that bulletins were being regularly sent to members.

1922—At the twenty-fourth meeting, committees were increased. A report on training executives was approved. The membership was then 1,600.

#### *Foreign Memberships Admitted*

1923—At the twenty-fifth convention, special membership was provided for hospitals in foreign countries, and the classification of nursing schools approved.

1924—At the twenty-sixth meeting, an honor roll of trustees, in service twenty-five years or more, with 457 names was established. The American Hospital Association accepted responsibility for National Hospital Day.

1925—Not long after the twenty-seventh meeting Doctor Warner died and was succeeded by Doctor Walsh as executive secretary. A personnel bureau was established. There were recommended (1) a new home, (2) bureau of research, (3) hospital and committee surveys.

1926—At the twenty-eighth meeting, Dr. A. C. Bachmeyer, in his presidential address, spoke of a lack of "group consciousness." It was suggested that an International Hospital Congress be held. An information bureau was inaugurated at the convention. On July 1, the American Hospital Association occupied its new home at 18-20 East Division Street, Chicago, bought at a cost of \$125,000. The Hospital Library and Service Bureau was given space in the new building.

1927—The twenty-ninth convention was distinguished by the fact that the *Quarterly Bulletin* was launched.

1928—During the thirtieth year preliminary work was done for the International Hospital Congress. Dr. Bert W. Caldwell succeeded Doctor Walsh as executive secretary. Recently the field of hospital administration has lost one of its outstanding leaders, our past president, Dr. R. G. Brodrick. Though we knew that he had been retired from the navy because of physical dis-

ability, we never saw an indication of this in any attempt to spare himself in any undertaking. His brilliant intellect and genial manners have left in our minds a monument to his memory even more enduring than the physical monuments, which he planned in the form of beautiful yet practical hospitals.

During the past year a most gratifying event has been the acquisition of the Hospital Library and Service Bureau by the American Hospital Association. While the bureau has been housed in our headquarters in Chicago for some years, we are confident that the closer relationship that is now being established will result in greater benefit being received by the hospital field, due to increased scope and usefulness.

The disaster at Cleveland called forth the sympathy of the whole world and especially of the hospital world. It is our hope and belief that the focusing of attention on this hazard will result in every possible precaution being taken by all institutions against such a catastrophe occurring in any other place in the future.

The increase in automobile accidents is most deplorable and the results, so far as hospitals are concerned, are unjust, for in many cases the hospital cannot refuse to admit a patient and yet often the hospital has to bear all the expense when the person injured is unable to pay and the owner of the automobile is without means and has no insurance.

#### *Workmen's Compensation Laws Not Uniform*

Another discrimination under which the hospital world is laboring is the unfair arrangement in regard to workmen's compensation cases. It is manifestly not right that an insurance company should with one hand be paying dividends to its stockholders and with the other accepting charity by not paying the full cost charges to a hospital. The laws in some states are more equitable than others but an effort must be made to bring them all on a fair basis to all concerned.

It has been a matter of much gratification that several additional state and geographic sections and organizations have been formed during the past year. It is to be hoped that this process will continue until the whole of North America is covered with state and provincial associations, all retaining a certain amount of individuality and special understanding of their own problems, but all united in the American Hospital Association for the benefit that comes from solidarity and from the strength that goes with numbers. This increase in state organizations will augment our individual membership as well as our institutional membership.

It is to be hoped that the healthy growth of our organization, in numbers, influence and finance, will be so impressive that when the time comes, as it soon may, that we shall need financial aid from outside sources, philanthropists when approached will appreciate our worth and respond favorably to our request. With increase in funds it should be possible to increase our personnel.

The suggestion has been made that the hospital association should maintain a research bureau. This is a matter that must be handled with great care because of the fact that such a bureau could ensure the success or failure almost overnight, of any given project by its seal of approval or disapproval. Consequently, its membership would have to be exceptionally well chosen, proper balances established and its methods of investigation most careful and impartial. In this connection it seems quite practicable to me that every hospital be a substation or department of a research bureau.

It has been said, and I doubt if anyone would contradict it, that every proposition that has resulted in progress in the field of hospital administration during the last two decades has been discussed at some time or other in the meetings of the American Hospital Association.

I wish to present what I believe is an answer to a need voiced by Doctor Bachmeyer in his presidential address, in his reference to a lack of group consciousness among hospital administrators. Some time ago I had occasion to use the book, "American Men of Science," and in it I found this statement:

#### *Urges Hospital Reference Book*

"As a reference book for the field it covers, it may be even more useful in academic circles than 'Minerva' or 'Who's Who in America.' But the chief service it should render is to make men of science acquainted with one another and with one another's work. There scarcely exists among scientific men the recognition of common interest and the spirit of cooperation that would help to give science the place it should have in the community. It is fully as important for the nation as for the men of science that scientific work should be adequately recognized and supported. We are consequently in the fortunate position of knowing that whatever we do to promote our own interests is at the same time a service to the community and to the world."

If there were substituted in these sentences the words "hospital superintendents" for "men of science," and "hospital administration" for "science," the statement would be equally true.

I would suggest that the book be in two parts,

one part devoted to a statement along the lines of the usual "Who's Who" in regard to hospital administrators and the second part devoted to a fuller statement about hospitals than any I am now acquainted with. It should give a brief history of each hospital, its governing body, its staff and organization, its departments, as well as its finances, somewhat along the lines of Sir Henry Burdett's "Hospital and Charities," but more in detail. It is my belief that such a book would be useful in informing hospitals about each other and hospital administrators about each other and would be of inestimable value to hospital trustees who are seeking to fill a vacancy, and to hospital superintendents wishing to obtain data in regard to a certain hospital or classes of hospitals. Such a book would aid in classifying and studying hospitals and hospital superintendents. I am hoping that the finances of the association will soon permit the publication of such a book and I believe that the interest of the hospital field in such a book would be great enough so that sufficient purchases would be made to permit it to be issued with very little net cost to the association.

#### *Code of Ethics Recommended*

While I am not sure that the time is yet ripe, it is my belief and recommendation that in the near future a committee should be appointed to draw up a code of ethics for hospital administrators. This code at the outset should be very brief and should embody only the few essentials that are of wide application and would be universally acceptable. After a start has been made the code should be built up gradually and carefully.

We have been immensely interested in the study that the Committee on the Cost of Medical Care is making, and during the past year the American Hospital Association has been asked to appoint a group to this committee and has complied.

The founding of the Human Welfare Group at New Haven, combining the facilities of the New Haven Hospital, the Yale School of Medicine, the Yale School of Nursing, and the Institute for Human Relations, offers many far-reaching and valuable possibilities.

All of these matters are ones in which hospitals are vitally interested now, and in which there will be increasing interest in the future. With the increase in population and the methods of modern living the use of hospitals will correspondingly advance so that hospitals will have to be considered more and more in the Cost of Medical Care and they will contribute in increasing ratio to the health of the nation and to improving human conduct.

# Hospital Laboratory Fulfills Many Functions\*

By R. L. KAHN, Sc.D.

Director of Laboratories, University Hospital, Ann Arbor, Mich.

THE laboratory in recent years has become an integral part of medical practice. Few present day physicians diagnose and treat patients without the aid of the laboratory and few hospitals are without some laboratory facilities. It is well, therefore, from time to time, to discuss the functions of the laboratory in medicine. Discussions of this kind are bound to prove of benefit to the hospital director, the laboratory worker, the physician and, above all, the patient.

It is difficult to discuss laboratory standards suitable for all hospitals. The laboratory needs of a tuberculosis sanatorium are obviously different from those of a metabolic clinic. It seems best, therefore, to present in this discussion, a picture of our work at the University Hospital, Ann Arbor, Mich. This hospital offers facilities for diagnosis and treatment in practically every specialty of medical practice. The hospital also constantly receives patients from far and near, with obscure disturbances that cannot be properly diagnosed or properly treated in the home communities. The laboratories of this institution

have therefore to be prepared to meet many calls from physicians. In addition, since the hospital is a part of the university, the laboratories have the functions of research and teaching. The laboratories thus have a variety of functions and in this discussion, I shall attempt to outline them briefly.

Obviously, the major function of the hospital laboratory is to extend every possible aid to physicians in their diagnosis and treatment of patients. In the laboratories of the University Hospital, we strive to perform this function by having laboratory workers who are highly trained technically, by employing the best available methods in laboratory practice and by being prepared to carry out these methods at all hours.

Workers intrusted with medical work should be especially well trained. These workers deal with biological reagents and methods of great complexity on the one hand, and with physicians rightfully expecting the best kind of laboratory assistance, on the other. Many examinations appear on the surface to be of a routine nature. Actually, however, biological tests cannot be of a routine nature, each one requiring special knowl-

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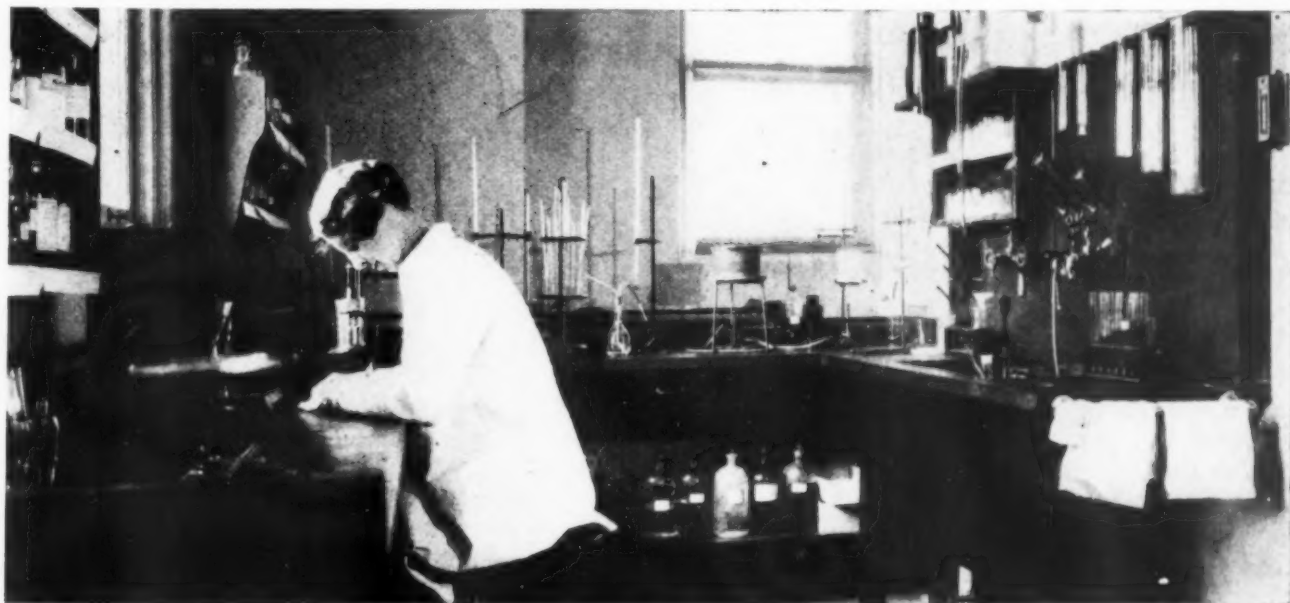
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Workers intrusted with medical work should be especially well trained. These workers deal with biological reagents and methods of great complexity on the one hand, and with physicians rightfully expecting the best kind of laboratory assistance, on the other. Many examinations appear on the surface to be of a routine nature. Actually, however, biological tests cannot be of a routine nature, each one requiring special knowl-

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Biochemical laboratory, University Hospital, Ann Arbor, Mich.

edge and most careful judgment for ideal results.

We strongly object to the term "laboratory technician" as a name for medical laboratory workers. This term makes us feel that in any given task, the hands play a greater rôle than the head. Physiological chemists, bacteriologists and serologists who have spent years in universities for special training, are obviously not technicians. We have technicians in the laboratories of the University Hospital who assist in the preparation of specimens for examination. But it is the chemist, the bacteriologist and the serologist who perform the examination.

#### *Which Method Shall Be Employed?*

Turning to laboratory methods, it is often a problem to decide, when several methods exist for one determination, which one to employ. Comparative tests of the value of the individual methods is the only procedure to follow in this case. Now and then it may be desirable to perform several tests on one specimen. Then again, there is the problem of determining the value of newly proposed methods. In the diagnostic divisions of the laboratories, we are thus dealing not merely with given, so-called routine examinations, but with problems of determining methods that give more ideal results.

When emergency demands, diagnostic tests are performed at any time, day or night, Sundays or holidays. This plan is in conformity with the emergency service extended by the medical and surgical staffs of the hospital. Conditions often arise that bring patients to the hospital at unusual hours and special laboratory examinations are required to help establish the correct diagnosis. The laboratory staff takes pride in being of assistance in such emergency conditions.

Diagnostic tests at the University Hospital are performed by two groups of laboratories. Qualitative urine analysis, blood counts and some examinations falling under clinical microscopy, are performed by interns in clinical laboratories which adjoin the hospital wards. Bacteriological, biochemical and serological examinations are made in the so-called central laboratories, and it is the work carried on in these laboratories that we shall consider.

Suppose we take a little time to look into the work of the bacteriological laboratory. We shall find three bacteriologists on duty. One bacteriologist is searching for pathogenic organisms in a given blood sample, which has been cultured on several types of media two days before. Another is performing a series of agglutination tests on a blood sample. The organisms employed in these tests are: *B. typhosus*, *B. paratyphosus A*,

*B. paratyphosus B*, *B. abortus*, and *B. melitensis*. These five organisms are used routinely with bloods sent to the bacteriological laboratory for a Widal test or whenever a patient has an undetermined fever. The third worker is attempting to differentiate between meningococcic and streptococcic meningitis with a view to determining the advisability of administering specific antiserum.

If we were to visit the laboratory at some other hour, we should probably witness the performance of an altogether different set of examinations. One worker would perhaps be taken up with what we call "autopsy bacteriology." Cultures are made of infected foci and of heart's blood in the case of all autopsies, and the bacteriological findings are correlated with the clinical and pathological findings.

Another worker is taken up with a different problem. This worker has just demonstrated *B. pyocyaneus* in practically pure culture in the stool of a patient. *B. pyocyaneus* belongs to the paratyphoid intermediate group and is not commonly pathogenic. The fact that this organism was present in such enormous numbers in the stool suggested to the bacteriologist to try agglutination tests with the organism against the serum of the patient. The agglutination-titer of the serum against this organism exceeded one to a thousand dilution. The results were reported to the physician who was able to institute treatment accordingly. This fact is stated to emphasize that each bacteriological examination is in a sense a research problem, and that the bacteriologist must often go further than the specific request of the physician to be truly helpful.

#### *Kitchen Supplies Examined Regularly*

We shall also observe some bacteriological work in the University Hospital that is related more to preventive medicine than to clinical medicine. The University Hospital prepares some 6,000 meals per day and the authorities are naturally greatly concerned that no spoiled food ever reaches the kitchen. The milk supply brought to the hospital is checked twice a week, especially for bacterial content. A fat analysis is also made. Then again, in the case of canned goods, all so-called "swells" are studied to determine the type of gas causing them. A "hydrogen swell" is considered chemical or mechanical due perhaps to overfilling the can at the time of packing. If, however, the swell is due to carbon dioxide, methane or other gases resulting from bacterial decomposition, then the food is condemned. All foods that seem at all suspicious are subjected to bacteriological examination.

Let us now turn to the biochemical laboratory

*A corner in the serological laboratory where blood specimens are submitted to the Kahn tests.*



*Three specialists at work in the research laboratory, University Hospital, Ann Arbor, Mich.*

where most of the tests are being carried out on blood. Most frequently we shall see blood sugar determinations—significant in diabetes and especially valuable in connection with insulin therapy. Then we shall see examinations of the chain of substances listed under the nonprotein nitrogen group—urea, uric acid, creatin and creatinin. All these substances are increased in the blood when the kidneys are incapable of properly eliminating them. In some other cases of kidney disturbance, blood chlorids are determined; in the condition referred to as nephrosis, cholesterol determinations are of importance. In gout, we have an increase of uric acid in the blood. Then again, we may see blood calcium determination which will show whether the tetany present is due to insufficiency of parathyroid secretion. In this case, the calcium content would be below normal. Phosphorous determinations are made in connection

with rickets; carbon dioxid capacity of the plasma is determined to establish the alkaline reserve of the blood. These and many other determinations are made daily in the biochemical laboratory.

Adjoining the biochemical laboratory is the metabolism laboratory where basal metabolic rates are determined on patients. Five Benedict-Roth metabolism machines and seven beds are available for these determinations, and from fifteen to twenty patients can be cared for in a morning. Time was when the measurement of the oxygen consumption of a patient was practically limited to disturbances of the thyroid gland. Now, however, basal metabolic rates are made in a number of disorders. In nervousness, palpitation and loss of weight, it is important to eliminate the thyroid as an etiological factor. Then again, pituitary tumors are known to depress the basal rate, the degree of depression be-

ing proportional to the severity of each case.

It may be of interest to note in this connection that determination of basal metabolic rates are being utilized in this hospital as an aid in prescribing "reduction" diets for obese individuals. By a simple calculation in the process of obtaining the metabolic rate, one can arrive at the daily caloric intake necessary for the obese individual to maintain body weight under rested conditions. Additional calories are allowed for the energy expended in daily routine.

Before turning to the serological laboratory, let us stop for a moment at the house physician's office. Here we shall see small amounts of blood being drawn from the arm vein of a number of newly registered patients. These bloods will soon be delivered to the serological laboratory for Kahn tests. By the time the patients reach the hospital department in which they are especially interested, the serological report will frequently be in the hands of the examining physician.

The rapidity with which the Kahn tests are reported at the University Hospital has proved a source of great satisfaction to the physicians and surgeons of the institution. Blood specimens reaching the laboratory at eight o'clock in the morning, usually withdrawn from patients the previous afternoon, are reported on at ten. Specimens reaching the laboratory at ten, are reported on at twelve, noon, and those coming about one-thirty are reported on at three-thirty. When the word "Emergency" is written on a blank accompanying a blood specimen, a report is made in forty-five minutes. The popularity of emergency requests may be judged by the fact that out of approximately 100 blood examinations a day, we often receive as many as ten emergency requests.

#### *Application of Kahn Tests*

Each blood specimen submitted to the serological laboratory is examined by the regular Kahn test which is conservative in sensitiveness, and by the presumptive procedure which is highly sensitive. These two methods are carried out with two specially prepared antigens, "standard" and "sensitized," and together with variations in technique, constitute independent tests. The presumptive procedure has three main functions: (1) As a technical check on the regular Kahn test, the employment of two methods tending to reduce error. (2) As a check on weak reactions with the regular test. The presumptive test being highly sensitive, it should be positive, whenever the regular test gives weak or borderline reactions. (3) As an additional criterion in establishing absence of syphilis. Due to the fact that the presumptive

procedure is more sensitive than the regular test, a negative reaction with this procedure obviously is of greater value in establishing freedom from syphilis than a negative reaction with the more conservative test.

In addition to these two tests, quantitative Kahn tests are made on the blood of patients who are receiving antisyphilitic therapy. These tests determine the number of serological units in the bloods of syphilitic patients and are of special value in treatment. The blood of a patient before treatment might show perhaps 600 serological units; after the first course of treatment, perhaps 420; after the second course, 180 units, and so on. The regular test during all these examinations is + + + +, giving no indication as to the relation between the therapy and the serological reactions.

#### *Special Test Made in Isolated Cases*

There is still another examination we occasionally make in isolated cases. We refer to it as a "special test" and it is made on the blood of patients who give some slight suggestion, either in the history or clinically, of the positive presence of syphilis. This special test is employed for the detection of traces of syphilitic changes or of so-called reagin in the blood. Due to the high sensitiveness of the technique employed in detecting traces of reagin, the negative result is of greater value than the positive result.

With regard to spinal fluids, the colloidal Gold and Mastic tests are performed in addition to the regular, presumptive and quantitative tests made as in the case with blood sera. It may be of interest to mention in this connection that a study recently made by Dr. K. M. Davenport of the department of dermatology and syphilology of the University Hospital on the clinical value of the presumptive reaction with spinal fluids, brought to light the following facts: (1) This spinal fluid reaction was found to be highly sensitive in detecting changes in the central nervous system due to syphilitic infection. (2) Some positive reactions were obtained with the presumptive test in patients who did not show clinical evidence of neurosyphilis, but all these reactions were obtained only on patients who have syphilis. (3) The negative presumptive reaction in practically each case corresponded either to absence of neurosyphilis or to cured cases of neurosyphilis. I mention these facts because it appears that we are dealing in this presumptive fluid test with the earliest indicator of neurosyphilis available at the present time, a fact that should serve as a stimulus to clinicians to search for clinical manifestations of this condition.

Let me touch upon a controversial point among

medical laboratory workers. Some believe that best results are attained in the serology of syphilis by the parallel use of the Wassermann and Kahn tests. By the Kahn test in this case is meant the regular diagnostic test with serum or with spinal fluid. Others prefer not to use the Kahn test and still others believe that best results in the serology of syphilis are obtained by using all of the several procedures included in the Kahn

test, that is intimately associated with our daily work. When laboratory findings in a given case correspond to clinical findings, our immediate duties in that particular case are completed. When laboratory findings, however, do not correspond to clinical findings, we immediately have before us a research problem. And this problem is not solved until the patient's condition is clarified.

As is well known, there are many diseases of



*The biological laboratory, showing the media preparation room in the rear.*

test. We belong to the last group and our reasons for this belief are based on many years of personal experience with the Wassermann and different tests for syphilis. We believe that the methods we employ in the diagnosis of syphilis at the University Hospital, constitute a system of great sensitiveness and dependability.

Due to the differences of opinion that exist in connection with different Wassermann techniques and with other tests for syphilis, the League of Nations Health Committee arranged a competitive conference on these tests, which was held at Copenhagen last summer. Altogether seven Wassermann methods and seven precipitation methods were tested on about 1,000 sera. The results of this conference will be published shortly in full and will show that the Kahn test came out ahead of all the other methods. Since only the regular Kahn test was used at this conference, it is obvious that the additional use of the presumptive and quantitative procedures would greatly enhance the value of our serological work. When we further consider the rapidity with which physicians at the hospital obtain the results, it is perhaps natural that we should take special pride in this service.

We look upon research as a field of endeavor

which the cause, cure or both are yet in the realm of the unknown. Our laboratories cooperate with practically every department of the hospital in attempting to throw light on many of these diseases. In cooperation with the department of surgery, the laboratories are studying the bacteriology of osteomyelitis, especially in children; with the department of internal medicine, the problem of gastric acidity; with the department of dermatology and syphilology and with other departments, the clinical value of syphilis tests in the presence of different pathological conditions.

In addition, the laboratories are concerned with other research problems, such as the nature of the reaction between serum and antigen in tuberculosis. If we could understand the nature of this reaction, it might be possible to develop a practical serum test for this disease. We are also giving considerable time and effort to the study of the mechanics of the serum reaction in syphilis. To this day, we have no criterion for cure in this disease, and our aim is to determine whether the positive serum reactions obtained after intensive therapy might be an immunity manifestation and not, as is believed by many, an indicator for further therapy.

Obviously, the hope of increasing our knowl-

edge in the diagnosis and cure of disease lies in special investigations. With this view in mind, we are not only devoting considerable time to research, but we consider it an important function to aid the younger members of the hospital staff in research investigations. We like to impress upon the members of the staff that the laboratories are open to them at all times—for consultations, for work on their own special problems and for any assistance that can be rendered to them.

The laboratories of the University Hospital, being part of a teaching center, have an additional function—the giving of practical courses in medical laboratory methods to qualified students.

#### *Demand for Technicians Increases*

The importance of laboratory practice in medicine has led to the steady development of larger and more numerous laboratories in this field. This in turn has led to an increased demand not only for persons adequately trained to direct the work of these laboratories, but also for still larger numbers of laboratory practitioners competent to carry on the routine and to assist in research investigations. Furthermore, the rapid development of the medical sciences is continually rendering available new apparatus and new methods, and the sooner these are brought from the realm of discovery to the world of practice, the better for humanity at large. In addition, therefore, to the training given by the university in the fundamental sciences, there is need for a practical educational program that will supply experienced personnel to carry on laboratory work.

Interest in laboratory practice as a profession has grown markedly among university graduates during the past decade. The development of knowledge of the relation of bacteria to disease and of biochemical methods to disturbances in metabolism, has made the medical laboratory an integral part not only of medical but of public health practice as well. Nor must a narrow view be taken of laboratory work. The importance of correct routine laboratory practice in medicine is well recognized. In addition, such practice often leads to discoveries that may prove of great public benefit. Because of these facts, practical courses in laboratory work are being given both for medical and nonmedical students.

We need hardly add that the laboratories we have been discussing represent only a part of the total laboratory service of the University Hospital. We have not considered the pathological laboratories, the x-ray laboratories and others associated with different departments of the hospital. We have limited ourselves to the so-called

central clinical laboratories which carry out bacteriological, serological and biochemical procedures. It is evident, however, from our discussion that these laboratories play an important rôle in connection with the care of patients at the university hospital. Few patients enter the hospital without some service being rendered them by these laboratories. Every patient's blood is tested for syphilis and most patients require also bacteriological or biochemical examination.

With the unusual growth of the laboratory in the practice of medicine, there is a tendency on the part of physicians to place perhaps too great dependability on the results of laboratory tests. We believe that no laboratory method should be accepted without due regard to clinical manifestations. Laboratory findings should aid but not replace clinical findings. In our opinion, the laboratory can best serve clinical medicine when the results of laboratory tests are carefully correlated with clinical observations.

We have touched upon a number of phases of hospital laboratory work. We have attempted to give a picture of the bacteriological, serological and biochemical laboratories and of research and teaching in a large hospital. But we have not said much about the laboratory worker who holds a unique position in medicine. On one side, he deals with the fundamental sciences and on the other, with the clinical sciences. His methods are derived from chemistry, bacteriology and related sciences and his materials are derived from the clinic. He knows the needs of clinical medicine and is in contact with methods of medical research. He is thus particularly fitted to contribute to the advancement of medical knowledge.

### **Caring for Infectious Diseases in General Hospitals**

That infectious diseases be cared for in wards operated in connection with general hospitals in cities, counties and towns of less than 100,000 population, is the recommendation made by Dr. Dennett L. Richardson, City Hospital, Providence, R. I., in a paper read at a meeting of the American Public Health Association.

The only essential requisite, according to Doctor Richardson, is that the isolation wards be under the supervision of a resident physician who has had experience in a modern contagious hospital, and that the nursing be in charge of a graduate nurse skilled in the nursing care of infectious diseases and in the technique necessary to prevent the spread of infection in a hospital.

Often patients sent to general hospitals are found to be suffering from some infectious disease or at least are suspicious cases. It is much less embarrassing to transfer them to isolation wards in the same hospital than to be obliged to send them home or to some isolation hospital. The patients also have the advantage of more adequate diagnostic and treatment facilities.

# The Patient Considered From an Individualistic Viewpoint\*

By ALPHONSE M. SCHWITALLA, S.J., Ph.D.

Dean, St. Louis University School of Medicine, St. Louis

**W**HAT is a patient? Frankly, I know of no single definition that will satisfy the hospital administrator, the doctor, the relatives of a sick person and the individual himself.

For the hospital administrator, the patient is an actual or prospective inmate of the institution; for the doctor, he is a caller at his office or one whom the physician himself is called to visit; for the relative, the definition of a patient varies with the qualitative and quantitative standards of human sympathy, human solicitude, human love; for the sick person himself, he becomes a patient through a complex of psychological, sociological and personal reactions. We generally define a patient as a sufferer from a disease, but this definition does not help us in determining the answer to our question. Suffering is an extremely elastic term; disease is no less elastic. The terms of our definitions are just as vague as the idea we attempt to define.

Arbitrarily we attempt to classify patients. From the physician's and the hospital's viewpoints there are ambulatory and nonambulatory patients. These terms, however, do not in any sense measure what we may call "patienthood," the condition in the individual that effects a suffering human being. Many ambulatory patients are much more sick than the inmates of our in-

stitutions. Many an ambulatory patient is closer to a crisis in his disease, closer perhaps to death, than his hospitalized neighbor.

The hospital administrator and physician also classify patients into medical, surgical and gynecological patients. Such a classification seems less

arbitrary. Yet we would probably all agree that there are but few medical cases that may not, under circumstances, become surgical cases and undoubtedly by far the larger percentage of surgical cases are also medical. We have, however, no way of strictly classifying, for example, an ophthalmological patient because we know definitely that many eye conditions are associated with ear, nose and throat conditions. We recognize this fact to some extent through our practice of inviting consultations but the arbitrariness of this procedure is also easily recognized.

Within the specialties themselves we classify

a case, for example, as pneumonia or typhoid fever, as carcinoma of the breast or sarcoma of the bone. Here again countless differences present themselves. We group our patients according to so-called "clinical entities," but what is a "clinical entity?"

In the midst of these countless paradoxes, do we not lose sight of the fact that the patient, after all, is still a human being? Temperament, character, constitution, remain the same whether a man goes about his business in office or factory or whether he lies prostrate upon a hospital bed. He

## Only One of a Kind

Recognition of a patient as a human being who is different from any other person in the world and therefore is deserving of the most careful individual consideration in the treatment of his ills, is here urged by Father Schwitalla.

The same individual attention that forms one of the deepest cravings of mankind is to be extended to every single inhabitant of our hospitals. And the same amount of study should be given to each patient within the limits of our resources and of our sympathy that would be extended to one who is nearest to us by ties of friendship or relationship.

Records, histories, progress notes, bedside notes, laboratory reports and reports of end results gain deeper significance when we realize that the patient in whom we are interested is the only one of his kind and that an individual answer must be given to his problem.

\*Read at the annual convention of the Catholic Hospital Association, Chicago, May 6-10.

has the same claims, the same rights, the same needs, the same yearnings, whether he walks about the street or whether he is immured in the ward of one of our institutions. What has happened to change him suddenly from the condition of being a nonpatient to the condition of being a patient?

The patient, I say, is still a human being and therefore he is still an organism. That organism is not isolated. It is still subjected to countless environmental influences, even though sick. Some of these environmental factors suddenly have played upon it and in the interplay between the individual organism and the environmental factors the organism has been prostrated. The battle between the individual and these environmental factors has been waged for some time. Gradually the internal forces in the organism itself have been spent and as these are spent the environmental factors gain ascendancy. Still the battle continues, for the individual organism—the patient—can recover through the processes of repair and through the ability to call upon reserve forces. Through an innate constitutional strength the battle may be won by the patient. If these intraorganic forces are deficient in magnitude or intensity the environmental factors will carry away the victory and the patient will succumb. Whether the environmental factors in this viewpoint happen to be a speeding automobile or a typhoid bacillus, a banana peel lying upon the sidewalk or the small-pox virus, inadequate nutrition or calcium hunger, makes little difference.

#### *Individual Organism Must Be Aided*

The essential thing is that during the period of combat or during the postcombat or precombat periods the individual organism must be aided in its strife and during these periods the individual human organism is a patient, a sufferer, if pain is associated with the combat. But suffering and patienthood are not necessarily synonymous terms. The process of waste may go on unperceived for a long period of time; the innate forces of the organism may have spent themselves without giving, externally, perceptible manifestations of this condition. Yet, even without suffering, that individual is still a patient.

Since the patient is a living human organism he is subjected even during the period of extremest stress to all the laws that govern the life of an organism. Among those laws the biologist recognizes one that in its significance for disease has been largely overlooked. The chemist, Le Chatelier, has told us that when an effort is made to change the closed system through some external force, the closed system will yield to external pres-

sure only as little as it can possibly yield. The system will actively oppose a change. At first, therefore, there is no relation between the magnitude of the external force and the internal reaction. It is only when the external force becomes progressively effective that the closed system yields more and more and when the moment is reached at which the tolerance of the system is completely overcome the external force exercises its overwhelming influence. It would be difficult to provide a more adequate picture of a fatal sickness.

#### *Normal Despite External Influences*

We have countless illustrations in the life of the human organism demonstrating the operation of this principle. External temperature may and often does exercise a profound influence on the human being. Despite this, we maintain a temperature that we call normal. Expenditure of energy during exercise varies enormously but despite this we maintain a relatively constant metabolic rate. The intake of food and the output of waste products tend of their very nature to alter the constitution of our body fluids. Yet, despite that fact, we maintain in our blood stress a hydrogen ion concentration that is remarkably uniform, and that uniformity is so essential to the organism that if a variation of more than a unit and a half or two units in the accepted standard scale of hydrogen ion concentration should occur, the human organism would have to pass through all the intermediate stages between deep coma on the one hand and excessive convulsions on the other.

We are apt to forget in such considerations as these that many diseases are not born of bacteria. Moreover, an invading organism like a bacterium or a protozoan parasite does not necessarily produce a disease. The conditions of the host organism is no less essential in the production of a disease. This thought in turn leads us on to another question, "What, after all, from the biologist's viewpoint, is a disease?"

I have already referred to our attempts at classifying diseases. That there is no unanimity of opinion upon what constitutes a particular disease is evident from the fact that so many classifications have been attempted and none of them has been universally satisfactory. Moreover, the situation becomes greatly complicated by the fact that while we think we can separate certain "clinical entities" it may be stated with a fair measure of accuracy that such a thing as a typical course of a disease is rarely if ever encountered. While certain phases in every disease are certainly typical, others are just as certainly

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atypical. Everything depends upon the interaction between the invading organism and the reacting organism, or in the case of constitutional disease upon the organism itself. We think that the symptoms of such things as typhoid fever or pneumonia are fairly definite, yet in a particular case we note diversities in the reaction that at times are so pronounced that our knowledge of symptomatology receives a rude shock. Why? Because the invaded organism was not in the condition to manifest what we have learned, from the study of other cases, to consider as the typical course of a disease.

Countless problems here present themselves. I have already raised the question, "What are clinical entities?" One of the heads under which we treat disease in our textbooks is symptomatology, yet every physician knows first of all that symptomatology alone does not present a clear cut, sharply defined picture of a particular disease. Fevers, headache, pains of other kinds, are generalized reactions that different so-called "clinical entities" have in common. If we consider the individual symptom, therefore, to be scientifically accurate, we should have to quote, if that were possible, the limitations or variations within which any particular symptom in a given disease could occur. By that very statement we are forced to recognize our limited knowledge of a particular disease form.

We have come to talk of "symptom complexes" and "syndromes" as if these adjuncts to a particular disease picture were more or less definite in their occurrence. Yet there is not an observing physician who has not seen almost any infective disease conquered by an individual organism without leaving certain deleterious after effects. These, however, are by no means uniform but vary according to some recondite factor in different individuals. The influenza epidemic of a few years ago offers a classical illustration. So many after effects of that disease have been described, ranging in their nature from chronic organic heart lesions to forms of mental deterioration, that it is well-nigh impossible to give a unified description of these after effects.

#### *Search for Specific Cures*

We still discuss in our schools of medicine certain specific diseases and with this antiquated viewpoint there is associated also the search for a specific cure for a disease. Let us consider this question of specific infective agents. What is the disease that is caused by the streptococcus? The suggestion has been thrown out repeatedly that the streptococcus that causes certain forms of scarlet fever, pneumonia, rheumatism and septi-

coemia is the same organism and that the particular picture presented by a certain patient is the result not only of the invading streptococcus but more particularly of the condition of the human being who is invaded.

#### *Physician Must Meet Emergencies*

In our old-time almanacs which were read with such avidity by the morose and morbid hankerers after self-analysis, specific cures are suggested for this or that "symptom complex." To-day the physician knows that if he wishes to help a patient through the period of stress that we call sickness, he must watch day by day the progress of the battle between the invading organism and the sick person. Emergencies are bound to arise and the physician must meet them. The heart begins to fail in its coordination and that emergency must be met; kidney function is disturbed and that emergency must be met. And so on throughout the entire list of possible emergencies, the modern enlightened physician cannot possibly rely merely upon a so-called specific cure for a disease and allow the patient to battle on in his severe struggle. All of these effects which arise in the organs of the sick organism are, after all, just as much a part of the individual sickness, as is the so-called specific effect from a bacterial invasion.

The analogy between the automobile and the bacterium as causative agents of a sickness is closer than is apparent at first sight. Even though the automobile always remains on the outside of the organism this wide divergence from one point of view may be considered purely accidental. The similarities are sufficiently great to merit further study. In both cases we have an external force which impinges upon the prospective patient. In both cases the point of attack is non-specific, that is, just as the organism may be struck by an automobile and the harm actually done to the organism may be determined by the point of impact, the readiness of reaction of the attacked organism, the special mode of reaction at that particular instant, and the weakness of a particular part of the body, just so each of these statements can be made also concerning the attack of the invading bacterium. All of this can be put into much more learned phraseology by saying that the effect of the bacterium on the organism is determined by the relative mass of the invasion, by differential response of the invaded organism and by the constitutional or organic weakness of the invaded organism. But in the end, whether we use learned sounding names or simple language, the meaning of my analogy is clear enough.

To summarize all of these thoughts, a disease is

an individualized response to an environmental stimulus. I say individualized to distinguish it not only from a generalized response but from a specific response. The physician in each case will be guided in his analysis of the situation by his knowledge not only of bacteriology but even more by his knowledge of the individual's physiological and biochemical reactions, as these are more or less determined by such structural and functional characteristics as are grouped together under the general heading of "constitution."

#### *The Individual's Contribution*

This brings us to our next thought—the individual's constitution. What is it? That it is not a simple thing to define is evident from the countless attempts at definition elaborated by so many students. The least that it can mean is this: Constitution is the sum total of the internal factors that make up an organism. For our present purposes we may restrict the discussion of it to those internal factors insofar as they are the basis of the reactions of a particular organism. Such a difference may seem abstract and vague and therefore unpractical and not helpful. Yet we have no way of attempting to describe directly the nature of human constitution. All that we can do is to watch the organism in its operations and from such data as thus may be assembled, deduce those characteristics we are seeking to discover.

Indirectly, therefore, we can accumulate a tremendous amount of information about the human constitution, and the volume of such information is growing with the advancing years and the accumulated results of scientific research. The easiest attack upon the problem of constitution is clearly through the structural avenue and such a solution has proved remarkably successful. The extensive studies of Draper, for example, show us distinctive measurements in standing height, in facial contour, various facial angles, sitting height, length of the head, circumference of the head, ear length and ear breadth, facial height, length of the mandible, length of the lower jaw and a great many other physical characteristics which, as far as we can judge, are diagnostically indicative in such conditions as gall bladder disease, gastric and duodenal ulcer, nephritic hypertension and tuberculosis. It is remarkable how the predisposition not only to these diseases but also to such diseases as pernicious anemia and asthma are reflected in the physical structure of the individual. Other workers, such as Taendler and Bauer, have pointed out that the day may not be far distant when physical measurements of face and head, hands, legs, chest and abdomen may be considered significant in the establishment

of a diagnosis. Our more advanced clinics even to-day are taking careful anthropometric measurements on all patients and as these masses of data are accumulated, without doubt they will yield a surprisingly rich harvest of conclusions.

All of this work is as yet in its infancy. Thus far we have concentrated such studies upon the adult male and the adult female, but as time goes on these measurements will be pushed forward into the years of senescence and senility. Even now some recent studies have shown the difference in bone and muscle contour in children of not more than two months of age and types indicative of predisposition to certain diseases have thus been established in the earliest stages of the individual's existence.

What is here stated of somatic disease has for at least two or three decades been recognized in connection with mental disease. Through the work of such persons as Kretschmer and Ewald human organisms have been classified into two sufficiently diverse types to enable the psychiatrist to determine his approach to a mental condition by the inspection of bodily conditions.

Yet, throughout all of this work the conclusion recurs that even though types are recognized the individual sick person is a problem by himself and that no matter what the indications may be, the actual course of disease cannot be so accurately prognosticated that a definite answer to each such problem can be given unqualifiedly.

#### *Environment Plays Important Part*

Human constitution taken in its most restricted sense is a product both of heredity and of environment. Heredity plays its rôle only in establishing tendencies. The environment makes these tendencies into realities, into this or that particular individual constitution. The same conclusions are here forced upon the student of disease as are forced upon the student of human character and the student of all human traits. A disease, like the character and the trait of the individual, is not predetermined by heredity in the sense that heredity forces the organism into a preestablished mold, but only in the sense that heredity fixes the limits of variability within which environmental forces may play their part in the fashioning of the individual.

We see from all this how important the environmental factor is in the determination of a particular disease. We used to think that races were differentially susceptible to certain diseases. Statistics have shown us that, for example, Negroes are much more susceptible to tuberculosis than are white men; that white men in turn show much more susceptibility to venereal dis-

eases than, for example, some of the wild tribes of Africa; that the latter in turn are much more susceptible to metabolic disturbances than are certain yellow races. All of these facts in the light of the newer knowledge have received a new interpretation—that differential racial susceptibility to disease is a direct expression of the influence of the individual's constitution. And since certain constitutions, as indicated to us by physical measurements, are more common in certain races than in others, the accumulated mass of facts now indicates to us the tremendous importance of individual traits in the development of disease.

Here then, in brief, is the biological conception of disease. A disease is, in the individual, a direct response to environmental factors. Whether these factors are bacteria or protozoan organisms or any of the other countless realities of life that affect the human individual is a matter of indifference, relatively speaking, for the establishment of our fundamental conceptions. Just what will be the reaction of the individual is determined not only by the nature of the attacking force but also by the nature of the attacked individual and that nature finds its expression in the individual human constitution. The human constitution in turn, while it cannot be studied directly, is still open to investigation by reason of the fact that certain structural and physical differences make themselves readily manifest to the inquiring mind.

The biologist thus places at the disposal of medicine a body of well ascertained facts upon which the physician may judge the prospective course of an actually existing disease, and what is still more important from the viewpoint of modern medicine, enables the physician to foresee the possibilities of the outcome of any struggle between the environment and a particular human organism.

#### *No Two Individuals Alike*

And where does all this lead us who are interested in the hospital? It emphasizes certain definite viewpoints. First of all the viewpoint that each patient is an individual not only in the sense that he is one human being, but that he is a human being of a special kind, so special that there is not a single human being in the whole combined population of all the countries of the earth who is just like him. From this viewpoint follow corollaries of the deepest import in our approach to the patient—that the same need for individual attention that forms one of the deepest cravings of mankind is to be extended to every single inhabitant of our hospitals, and that the

same amount of study should be given to each patient within the limits of our resources and of our sympathy that would be extended to one who is nearest to us by ties of friendship or relationship.

For administrators the thoughts I have here tried to develop have a deep significance insofar as these thoughts emphasize the necessity of studying each individual patient. Records from this point of view, histories, progress notes, bedside notes, laboratory reports and reports of end results gain a deeper significance when we have caught the thought that the patient in whom we are interested is the only one of his kind and that an individual answer must be given to the problem this patient has brought into our hospitals.

### Collecting Bills in the Hospitals of New Jersey

In order to determine the main sources of hospital income in New Jersey, a study was made of forty-one general hospitals in the state. It was discovered that toward the average cost of \$5 a day, the patients themselves contribute \$3.22 or 66 per cent, local governmental agencies contribute sixty-four cents or 13 per cent and the remaining cost of \$1.14 is made up by private generosity through contributions, donations, income from endowments and other funds and income from miscellaneous sources.

The hospitals studied report that they have adequate machinery to collect from those patients who are able to pay and to ensure against abuses of free hospital service. Every hospital arranges with the patient, or those responsible for him, about the bill. Usually private and semiprivate patients are asked to pay a week in advance and ward patients at the end of each week. There is no hard and fast rule about this, however, because the hospitals do not want to commercialize their services to the detriment of the human side.

Whether the patient is admitted on a free or part-pay basis depends upon the attending physician or the medical staff although as a rule some kind of social service investigation is made which, if the hospital is a large one, may go into great detail. A less extended investigation may be made by a committee of the board of managers, a member of the board of freeholders, the district nurse, the city social service department or charity organization, the overseer of the poor, a county investigator, or even the business office of the hospital or a credit bureau of rating.

Unpaid accounts are followed up after the patient leaves the hospital. This may be done by letters, statements or even personal visits. Thirteen hospitals definitely use collection agencies when bills are not paid. Five turn unpaid accounts over to the hospital attorneys. In one large hospital, the patient before leaving is required to sign an agreement covering any unpaid amounts. After three months this is followed up by a financial investigator.

In the other hospitals, the business manager, the staff bill collector, the board of managers, the social service agencies and the constable may function in the collection of unpaid accounts.

*Cool forest scenes showing glimpses of rippling water adorn the walls of the visitors' dining room, furnished in graceful mahogany pieces.*

TO describe the new Passavant Memorial Hospital on the McKinlock campus of Northwestern University Medical School, Chicago, is to describe a notable achievement in interior decoration.

This hospital is architecturally striking; it is modernly equipped; it has all the facilities that are demanded of the teaching hospital of to-day, but when the hospital was thrown open for public inspection on May 21 it was none of these things that called forth from the visitors a chorus of unqualified approval. It was the scheme of decoration that drew immediate comment; it was the skillful use of color that won praise; above all, it was the evidence everywhere that a connoisseur's knowledge of furniture, an artist's love of color and an expert's attention to minute detail had governed the interior arrangements of the entire building—it was these things that brought about the general verdict that here was a new departure



## Capitalizing Color of the Interior

By JANET PETERKIN, Assistant Editor,

in hospitals and here at the same time was a monument to unflinching good taste.

We have not hitherto been accustomed to think of hospitals as coming, to any great extent, within the sphere of the professional interior decorator. But we must readjust our ideas and gain a new viewpoint for here and there among the newer institutions we find that rich furnishings and draperies and period furniture have been introduced, that color has been employed to good advantage. It is sometimes remarked that the lobby of a certain hospital resembles that of a hotel



*A black ceiling provides a striking note in the board room, distinctive in its rich and dignified furnishings and draperies of green and gold.*

this hospital is the sense of reposeful harmony that greets us as we enter and goes with us where we go. Refreshing color and well chosen furniture are to be seen on every hand and create an inviting air of hospitality throughout the whole building. We do not merely find here and there a pretty room as an oasis in the midst of barren corridors, bare waiting

## Appeal by Means Decorator's Art

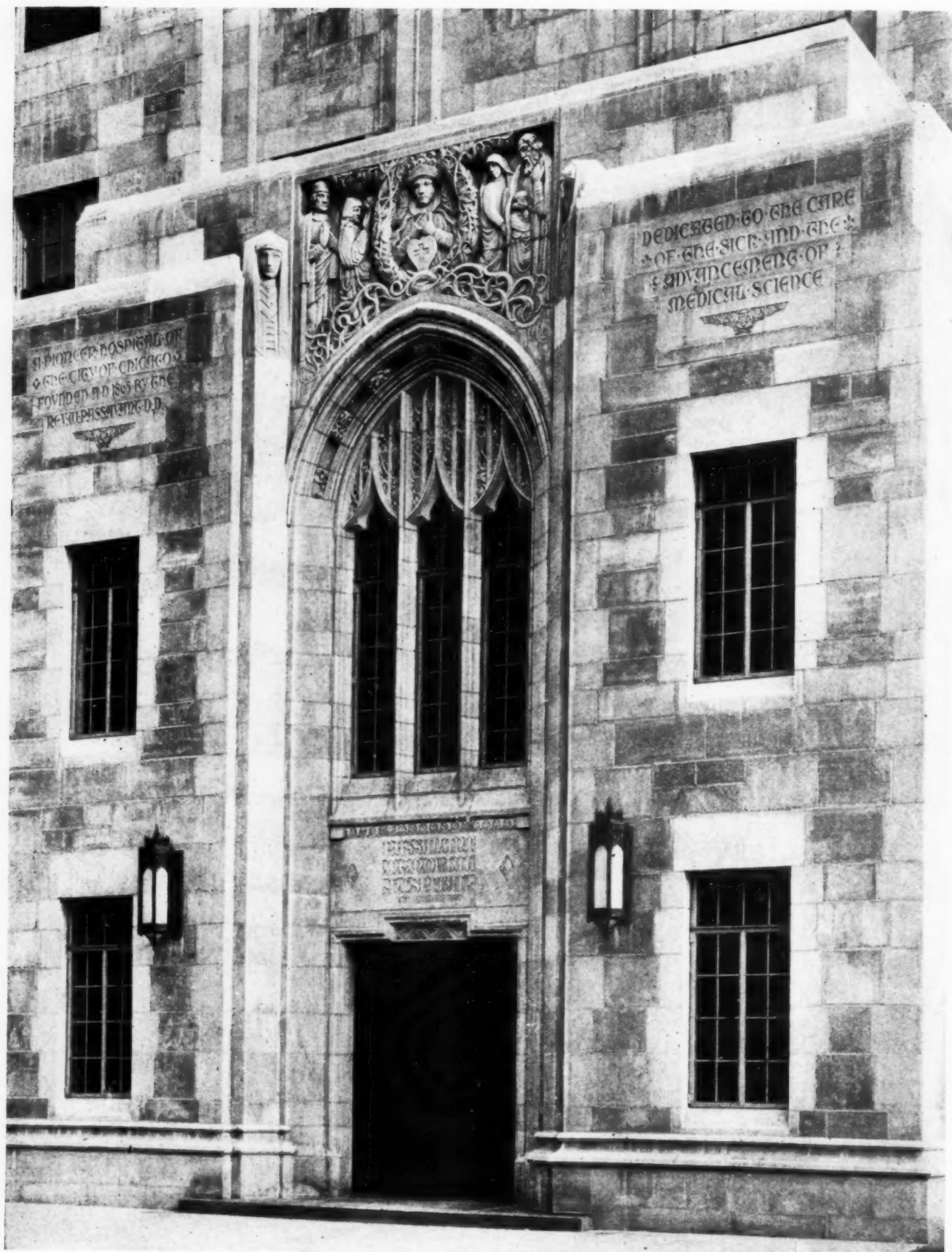
THE MODERN HOSPITAL, Chicago

or of an exclusive club; that at last the traditional hospital atmosphere has been banished. Passavant may be said to have gone one step farther, for it suggests in some respects a home, the home of one who has conservative tastes but who nevertheless keeps in close touch with modern ideas. And can we compliment a hospital more subtly than by saying that it suggests a home, for is it not indeed the patient's temporary home and should we not always strive to create for the sick a homelike atmosphere?

What impresses us most in making a tour of

rooms and uncheerful wards. Everywhere there is evidence that the hospital has been studied and planned for as a whole and not in piecemeal fashion, with an understanding of the fundamental principles of colors and their relationship.

In these days when the psychological importance of environment is so widely recognized and its significance in relation to the sick is acknowledged by all, it is no mean achievement thus to create for Passavant's patients a background that will unfailingly produce a sense of well-being and will remove that feeling of unnatural surround-



*The main entrance to Passavant Memorial Hospital is impressive. Dedicatory legends are placed high at each side of the stately Gothic arch.*

ings that proved a mental hazard and that must have handicapped convalescence in the hospitals of a past age. The physician could have no more valuable aid in his treatment than the attitude of mind encouraged by a gracious and restful environment.

It is impossible here to describe in detail the many attractive features of this institution, but let us visit a few outstanding rooms and get a general idea of what has been accomplished.

The keynote of the hospital is struck in the main lobby on the first floor. This beautiful Tudor entrance hall was designed by Mrs. John Alden Carpenter, Chicago, and bears testimony to her understanding of good lines and pleasing proportions, of color harmony and suitability. It is a spacious room, extending the entire width of the building. At the south end it opens on to a sunny terrace. The oak paneled walls give a rich and sumptuous appearance and form an effective background for the soft-toned color scheme of rose, green and beige. On the floor is an oriental rug, the predominating color being rose, and at the windows are curtains of beige and handsome draperies of rust red velvet. The long table in the center of the room is of oak in antique English style. On it are two heavy brass lamps with parchment shades and a decorative pot with a growing plant. Davenports and convenient little old English tables are sensibly distributed and the atmosphere of the room is pleasantly informal and neither overwhelms nor conceals the important points.

The architect has set the windows back in cleverly conceived niches, which offer an opportunity for distinctive treatment and for the introduction of some of the pretty accessories that are important in fitting up a room. Here are

two benches upholstered in varying shades of striped damask, and a desk with an oak bench in front of it completes the pieces of furniture. On the desk have been placed two lamps similar to those on the center table, a writing pad and gay colored quill pens and two ornamental pottery penguins.

East of the main lobby is the superintendent's room. This is essentially a man's room. Paneled walls, a massive desk and dignified chairs, as comfortable as they are important looking, have their simplicity set off by rich red window draperies.

This color note is echoed by two exceptionally handsome lamps, well placed to brighten the room. These are of crimson metal, decorated with gilt, the shades being in the same tones.

In the nurses' lounge, a large sunny room, the rug is green and the walls are yellow. The davenports and large comfortable chairs have slip covers of gay chintz in delightful colors and patterns. There are many windows, some of which overlook Lake Michigan. These have sash curtains of pale

yellow, the draperies being of green velvet to match the rug. Heavy matching French commodes give a pleasingly well balanced effect. On the long table are two lamps of striking shape and coloring, with plain parchment shades. In addition, many small tables are scattered about the room and two restful oil paintings are on the walls.

Next to the lounge is the nurses' library, an important room from the standpoint of decoration. Built-in book shelves are on three sides of the walls which are painted green. At the windows are sash curtains of vermilion silk which diffuse a rosy glow as the sun streams through them. A black marbleized fireplace gives the welcome suggestion of home. Over it hangs a fantastic and colorful Japanese print. The chairs and



*An airy freshness marks the solarium on the eleventh floor.*

davenport are covered with chintz in tints of green and red and beside them are Chinese red lacquered end tables that repeat the color of the curtains. A graceful piece of furniture is the French secretaire, of artistic design and pleasing proportions. The rug is mulberry colored and a crystal chandelier and side brackets complete the picture.

Special mention should be made of the small lobby on the ground floor, which is the visitor's first introduction to the hospital as he enters through the main doorway. This lobby is entirely paneled in butternut, which has a depth of glow and rich gold color that is a delight. A small information desk, glass enclosed, is of the same wood. On the left a spiral stairway leads to the main lobby on the first floor.

On the ground floor are several rooms that deserve comment, notably the board room and the visitors' dining room.

#### *Dignity Marks Board Room*

In the board room we remark at once the black ceiling, with three beautiful crystal chandeliers of Empire style. This feature gives the room a striking appearance which is emphasized by the dignity of the furniture. The walls are a rich yellow, and handsome gold colored silk curtains drape the windows. A long table is in the center of the room and the chairs are upholstered in dark green leather. Two richly decorated Empire mirrors are on the walls and these and a beautiful Japanese flower pot with a growing plant soften the severe simplicity of this beautiful room.

The visitors' dining room is enriched by the attractively decorated walls, which represent a forest in the springtime, with glimpses of blue waters and above a pale gray-blue sky fading into white. The chairs have graceful mahogany frames and are covered with cream colored kid leather with a pinkish tinge, and there are sash curtains of the same shade. Small square mahogany tables and a buffet sideboard complete the furnishings, and a crystal chandelier and wall brackets add a decorative touch to the room.

Outside each elevator is a fascinating green waiting alcove where relatives and friends may await permission to visit a patient. The walls are green and the dado represents a terrace overshadowed by heavy foliage. A French scenic wall paper has been used and has received several coats of glaze so that it is washable. Large exposed pipes, which might be so disfiguring, have been painted in the same design as the dado so that they melt into the general scheme and become entirely inoffensive. This is a good example of the attention to detail that is so marked a feature of

the decorating scheme. Emerald green silk curtains are at the windows. Several comfortable chairs upholstered with green leather are here and a standard lamp of modern design adds appreciably to the attractive appearance of this corner.

In the bedrooms different color combinations are used on different floors. Two floors are done in yellow, three in pink, one in blue and two in green. Let us pause in one of the *de luxe* rooms, with a southern exposure and plenty of windows and sunlight. Here we find a range of yellows, with the floor covered with a taupe rug. The walls are painted a pale primrose tint. The woodwork, including the doors, is a trifle darker. The bed cover is of casement linen in a mellow amber color, a richly embroidered monogram in brown and different tones of yellow, appearing in the center. At the windows are ruffled curtains of primrose organdy. The furniture, consisting of a bed, a low chest of drawers with a hanging mirror, two small bedside tables and an end table, a flat topped desk and a hanging bookshelf, is of white walnut in the French provincial style.

The bed was especially designed for Passavant to correspond with the furniture chosen. On it we find the softly colored floral design and the same graceful curves that appear on the dresser and on the other pieces in the room. The rounded end of the bed corresponds with the rounded top of the mirror and this rounded motif appears again on the wall as a rather faint design of deeper yellow above the bathroom and closet doors, and is suggested in the graceful draping of the window curtains. This is another example of the thought that has been expended on the finer points that are frequently overlooked and that combine to produce a harmonious whole. The room was planned on the principle of the proper balance of dark and light, no color being too strong or too weak. Such a room fulfills the essential requirement of a sleeping room—that it be restful.

#### *Special Lighting Adds Comfort*

In addition to the furnishings mentioned, there are two straight chairs, covered with green leather, a large easy chair, with stool to match, both having flowery glazed chintz covers, a standard lamp, a large bedside lamp and two small dresser lamps. The lamps are all similar in color and design, being of cream color with antique brownish finish and brown shades. The lighting is of the indirect type, the bedside lamp being fitted with a reflector that throws the light toward the ceiling. In no private or semiprivate room are there any overhead lights or wall brackets. The over-the-bed table is painted to match the general

*A black marbleized fireplace is a distinguishing feature of the nurses' library, shown at the right, and gay chintz covers the comfortable chairs in the adjoining nurses' lounge.*

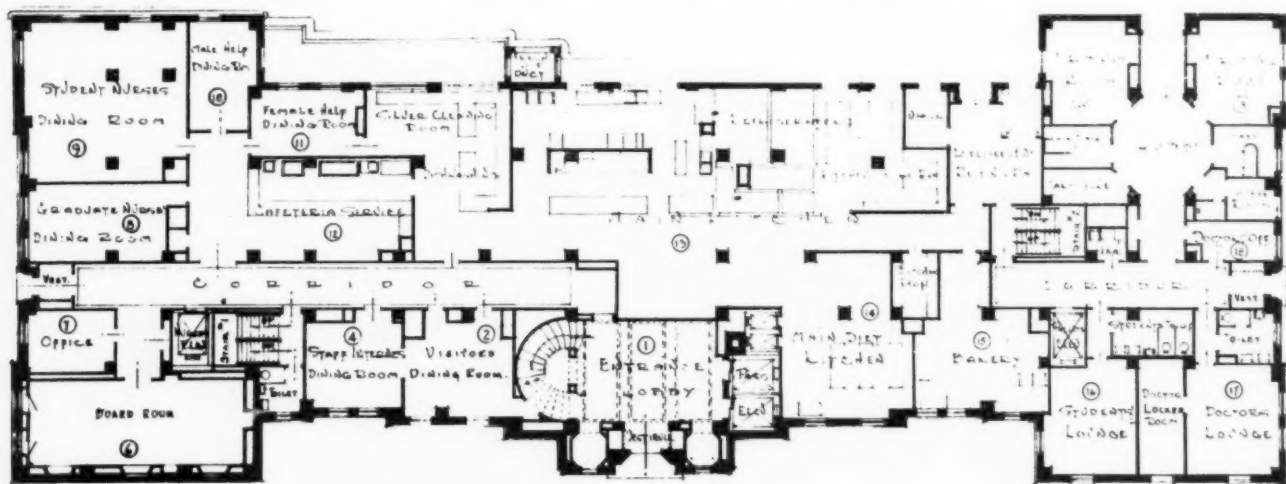


scheme. Its top is adjustable and may be raised to any angle to form a book rest. This room and others that are similar is spacious and the furniture is not in any way crowded.

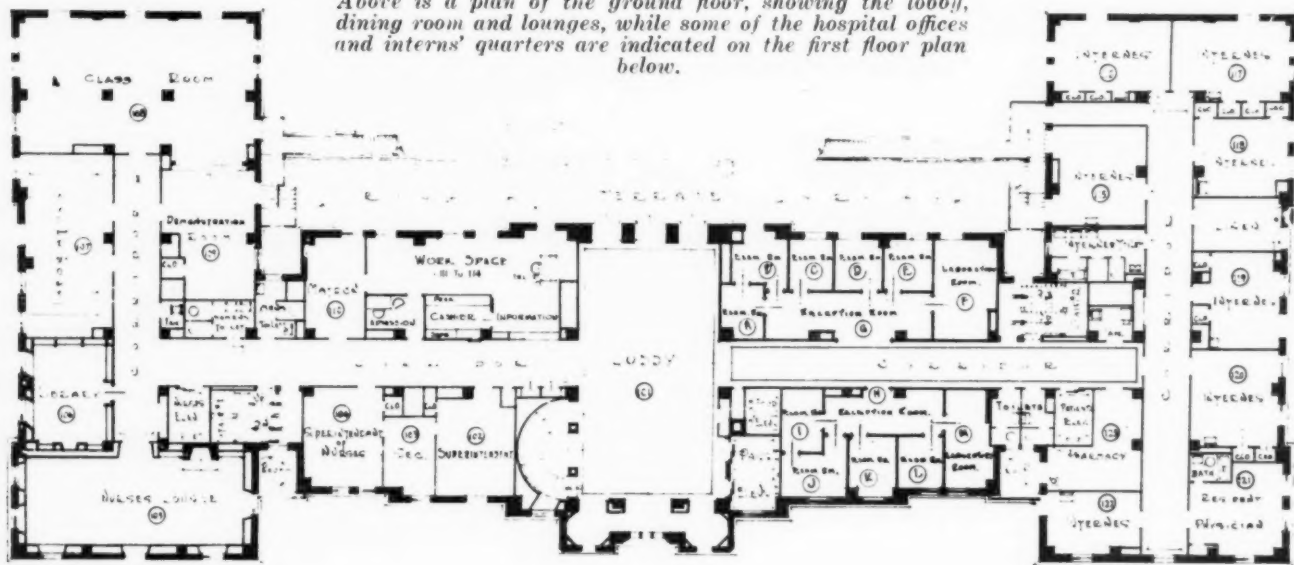
Stepping into the corridor from this yellow room with its green chairs, we find that the corri-

dor walls are green, and the windows at the far ends have yellow curtains, a clever tie-up with the glimpses of yellow that are visible through open doors on this floor.

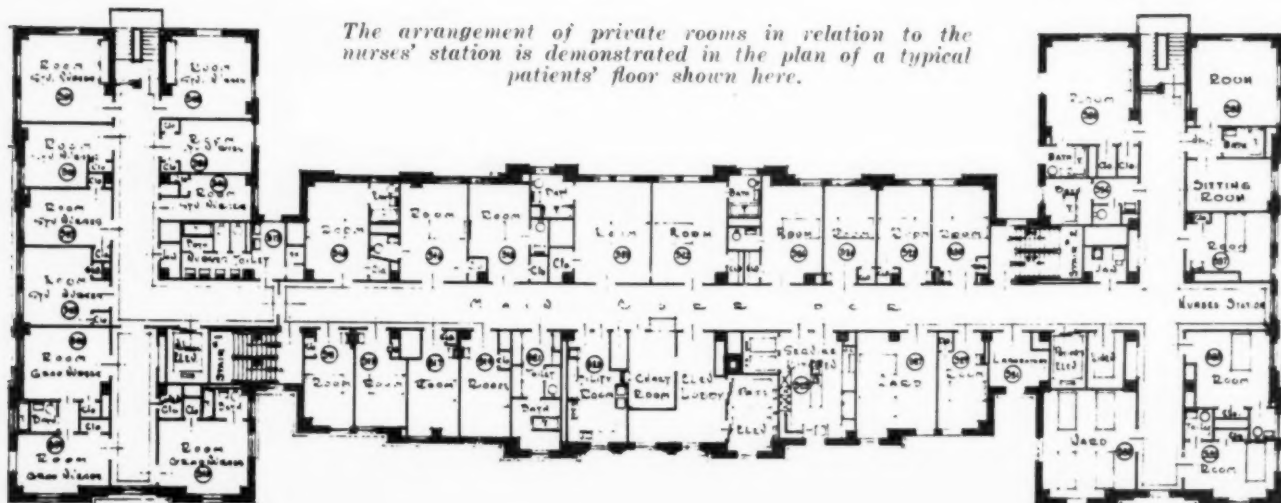
On other floors different color combinations are used. For example, in the blue rooms the bed-



Above is a plan of the ground floor, showing the lobby, dining room and lounges, while some of the hospital offices and interns' quarters are indicated on the first floor plan below.

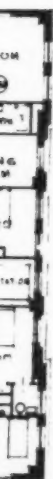


The arrangement of private rooms in relation to the nurses' station is demonstrated in the plan of a typical patients' floor shown here.



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spreads are a soft peach pink. In some cases the window curtains are also of this shade; in others, glazed chintz is used for these draperies.

In the less expensive rooms the furniture is of painted metal and the same care has been given to matching and combining colors and working up a pleasing atmosphere. In rooms having two or three beds, screens have been placed, so that a

The setting that awaits Passavant's babies in the nursery on the eighth floor is surely as lovely as any mother could wish. The room is large and sunny, with many windows. Here the predominating color is a soft peach pink. Dainty organdy sash curtains of this color are at the windows. These are very full, deeply scalloped at the ends and picot edged. The bassinets are painted the



*Constructed of Bedford stone in semi-Gothic style, Passavant Hospital is an outstanding architectural achievement.*

certain degree of privacy may be ensured to each patient. These are non-tippable and set on casters. The frames are painted in the predominating color of the room and the material used for the window draperies appears again on the screens. All the curtain material used in the hospital is both sunfast and tubfast and before use has been subjected to severe laundry tests. The chintz used on chairs is washable.

The wards are large and light, one nine-bed ward having six windows and a four-bed ward having three windows. The color schemes are the same as those used in the private rooms on the respective floors.

same color and will accommodate forty babies. The walls are pale yellow and on them a noted Russian artist with brush and colors has painted apparently at random whimsical sketches of miniature dancing figures, fantastic steeds tossing their manes, flying fish, elephants, lions and other subjects, the whole being a fanciful conception of a juvenile circus. On one wall is a gigantic kangaroo stretching his tall neck to the ceiling. Beside him is dancing a small and impish clown and at his feet is a baby kangaroo. The designs are in white and pink, touched up with deeper pink, blue and purple.

The solarium runs across the building on the



*One corner of a bedroom showing, through the small entrance hall, a glimpse of the sitting room beyond. These two rooms with bath, form one of the luxurious patient suites.*

eleventh floor and has a southern exposure. In order to create an out-of-doors illusion here a wall paper with a trellis design has been chosen and ivy, growing plants and flowers in stands and wall brackets play an important part and bring a charming note of green freshness. Green is, appropriately, the dominant color note here, and is found in the rugs, the curtains, the cushions of the reed chairs and the rep cover of the settee. The cushions on one or two chairs are covered with a vivid shade of brick red, which gives the necessary accent and enlivens the room. An iron table with a black glass top has on it a metal stand with decorative artificial flowers. Casement windows have been used here as being preferable to double sash windows, since they allow the full length of the window to be open, a desirable feature during the warm weather months when we try to lure every passing breeze. Ultraviolet ray transmitting glass has been used in all the windows in the solarium.

A small sun room which opens off the large solarium indicates the modernistic trend in decoration. It is an admirable example of how to be distinctly new without being bizarre or costly. Simplicity is the keynote, the wall paper being the only decorative feature. This has a dull black background, with the design in mauve, green and white. Pale orchid curtains of an open mesh

material are at the windows and the reed chairs are painted black and have cushions of a metallic fabric of a steel gray color. The modernistic lighting fixture in the center of the ceiling is of an exceptionally attractive design. For a room that is not to be lived in continually the treatment is excellent. It was planned by John Hopkins, Holabird & Root, architects, Chicago.

Those responsible for the interior beauty of Passavant Hospital are to be warmly congratulated. The result has not been attained without effort. Time, energy and enthusiasm have been expended unsparingly by Dr. Irving S. Cutter, the superintendent of the hospital and dean of the medical school, Mrs. Joseph G. Coleman, Chicago, president of the Women's Aid Society, Mrs. Francis J. Johnson, Chicago, chairman of the decorating committee, and Elizabeth Hofflin, New York, who, since last November, have labored to make this institution an attractive haven for the sick. Nothing has been overlooked that could contribute in any way to the welfare, comfort and happiness of patients and personnel. If anything could rob bodily ills of their terrors, mitigate gloom and dispel despair, it would be these charming, sunny rooms, with their lovely coloring, their gay chintzes, their chic furnishings.

Some may question whether utility and efficiency have here been sacrificed to beauty. Is it

possible, they may say, that a hospital so pleasing in appearance can be as hygienic, as sanitary, as aseptic as the bleak institutions we have for so long been accustomed to associate with ailing bodies and sick minds? A little reflection will surely prove that it is entirely logical for hospitals to change with the changing times. In the last fifty years the scientific side of the hospital has been revolutionized, and there is no reason why a twentieth century hospital should continue to trail with its practices that were developed to fit a by-gone age. There is no virtue inherent in staring white paint. The softest and loveliest pastel shades may be as hygienic if they are kept clean.

#### *No Need for Ugliness To-day*

Undoubtedly there once was justification for the inevitable white that greeted one in every hospital, for the hard floors, the bare walls, and the stark windows, for the complete absence of anything pleasing to the eye or anything that would soften the outlines. In those days colored fabrics and colored paints quickly faded in the sun and in the laundry. Rugs and upholstered furniture absorbed dust steadily month by month until the annual or semiannual upheaval when they were sent away to be thoroughly cleaned. It would have been regarded as folly in those days to suggest introducing draperies, upholstered chairs and colored bedspreads into a hospital. To-day the situation is vastly different. Fabrics in silk, cotton and wool that are sunfast and tubfast are now everywhere available. Vacuum cleaners can be requisitioned daily to rout dust. Washable wall papers are on the market. Why, then, need a hospital be ugly? Why must it depress instead of cheer?

The cornerstone of the new building was laid in June, 1926, and the completed structure, which cost approximately \$2,000,000, has just been opened for the reception of patients. Accommodations are provided for 325 patients but until a nurses' home has been built the east wing of the hospital will house 100 nurses. Faculty members of the university school will comprise the staff.

In this hospital the architects, Holabird & Root, Chicago, have reached a high mark in hospital designing and planning. The exterior of the building is semi-Gothic in type and Bedford stone has been used, harmonizing with the architecture of the buildings on the McKinlock campus. The construction is reinforced concrete and steel and is fire-resistive. Floors are of terrazzo throughout, except where concrete is covered by rubber tile.

The main entrance for patients and visitors is on the ground floor in the north center. From this a spiral stairway leads to the main lobby above on

the first floor. The nurses' entrance is at the east end of the building and the entrance for doctors and students is on the west, while ambulance patients and emergency cases enter from the drive on the south. Near the ambulance entrance are two emergency operating rooms, first aid rooms, waiting rooms, a doctors' and students' lounge and lockers.

A study of the accompanying floor plans will make plain the space allotment, which has been planned with careful attention to conserving space, saving steps for the nurses and reducing to a minimum the retracing of pathways.

On the first floor the telephone operator, the cashier and the information clerk have been placed in close connection for economy of operation, and the registration room is near the cashier.

A very complete laboratory is located in a series of rooms on the second floor, where are also the physical therapy department and the x-ray rooms.

The third, fourth, fifth, sixth and ninth floors are used for patients' rooms. Each floor has one quiet room, completely soundproofed, a diet kitchen and necessary utility rooms. On each floor is also a small laboratory for routine examinations, chemical and pathological.

The seventh floor is used in part for maternity cases and the eighth wholly for maternity cases. The department of surgical obstetrics includes two delivery rooms, adequate labor rooms, sterilizer rooms and bath equipment.

The tenth floor contains the five operating rooms, with their necessary workrooms, sterilizer equipment, instrument rooms, physicians' and nurses' scrub-up rooms and plaster room and dental room. An anesthetic room is conveniently placed between each suite of operating rooms.

#### *Nurses' Station Overlooks Corridor*

The nurses' control station is in the center of the corridor near the elevators, and from it the head floor supervisor can view the corridor from end to end. Her desk projects into the corridor and is glass enclosed. At the end of the corridor is the assistant floor supervisor's station, with ample space for records and a cabinet.

Approximately 60 per cent of the bed capacity in this hospital is allotted to rooms and wards priced at \$7 and under. The ward rates are \$4, \$4.50 and \$5, according to the size of the ward. There are twenty rooms priced at \$6, twenty-eight at \$7. Other rooms range in price from \$8 to \$25, there being only two rooms priced at the latter figure. There are also in the hospital three suites, each consisting of a bedroom, a sitting room and a bathroom.

# Why So Many Changes in Hospital Personnel?\*

By JAMES L. BEVANS, M.D.

Director, John D. Archbold Memorial Hospital, Thomasville, Ga.

THE real title of my paper is "Trouble." Why do so many hospital executives leave their positions, voluntarily or by action of their boards, their tasks unhappily not accomplished? It is a vexing problem that this paper considers and it is a human problem. Every hospital executive knows that thermometers break, that fuses burn, that dirt accumulates and that foods spoil, but these are not the problems that make him pace his office, that disturb his rest and distress his soul. It is the unfortunate interrelations of human beings attempting to work in groups that make hospital executives quit work or that lead to the sentence, "Services no longer required."

Countless times the board, the superintendent, the staff, the training school have been passed in review in an effort to find the source of the trouble, every feature of hospital life has been studied in a futile search for the cause of the difficulty, hospital literature teems with discussion of all sides of the question, while Satan stands in the background grinning at the interminable enmeshment brought about by the inherent weakness of mankind. While men and women are progressing in idealism and group discipline, it is well for the hospital world to pause and recognize that the institutions are not merely structures of stone and iron but groups of human beings exercising their vocations and striving as best they may in the presence of all sorts of instinctive human reactions and weaknesses, to reach as high a standard as is possible.

## *Many Causes for High Turnover*

The causes for the high turnover in the ranks of hospital executives have been many. Self-perpetuating boards of trustees, boards in the hands of cliques or financial groups, boards having active medical members, boards affected by favoritism toward this or that superintendent, toward one staff member or toward a group of physicians, have been prominently mentioned as trouble-makers. Boards have been criticized because they forget that their functions are policy-forming, because they fail to maintain professional stand-

ards by the appointment of a competent staff, because they do not select and support the executives who direct the personnel. The board that does not represent in its membership a fair cross section of the community—the banker, the baker, the candlestick maker—is unfortunately constituted. The board that allows any of its committees except the executive committee to have other than advisory power is heading toward discontent. The committee-ridden hospital is unhappy. The dispersion of authority among special and extra committees is regarded as unfortunate.

## *Staff Is Frequent Source of Trouble*

The staff is frequently commented upon as a source of trouble for hospital executives. Many hospitals have found it wise to limit appointments of staff members to one year, on the theory that it is easier to fail to reappoint than it is to dismiss undesirable members of the staff. All hospitals and even the courts have come to recognize that responsibility for maintaining a high grade of care of the patient through the careful selection of professional men on the staff rests solely upon the board. The staff doctor's bread and butter is too deeply involved to permit him to take a broad view of the hospital's administration. Also there is something inherent in the practice of medicine that keeps its followers from developing executive powers. The doctor's every effort is bent on giving service to the patient. Without doubt executive powers are latent in many doctors, as history has shown by striking examples, but active practice does not lead to their development. Perhaps the greatest source of trouble proceeding from the staff is that its members are not employed and paid by the hospital as are the superintendent and other employees. They, with their patients, are customers or patrons; they are on the other side of the counter from the administrative staff.

The training school and its relationships with the hospital have been a fertile source of trouble. It is natural that the hospital director should think first of the hospital and that the superintendent of nurses should think first of the training school.

The director of the hospital has relations with

\*Read at the meeting of Georgia State Hospital Association, Macon, Ga., May 7, 1929.

the board, the staff, the training school, the community and the various departments of the institution, and these relations have given rise to endless discussion.

The causes of turnover in executives that I have named do not seem to me to reach the heart of the subject. The problem is rather one of group psychology, of the relationship between leaders and subordinate leaders with their groups, of how idealism and organization can help the individual to find himself.

Analysis makes it evident that there are many groups within groups and even overlapping groups in the hospital. In the consideration of the subject it is necessary to remember that all groups of any size are made up of the leader, the subgroup leaders and the followers. The psychology applies alike to the director, the superintendent of nurses, the professional men and to any of the departments of the hospital whether they are definitely organized or not.

Let us take the individual member of the group first. Down underneath the superstructure of his culture, custom and civilization, are a lot of strange, elemental processes, familiar to everyone, which spring from within and nearly have their way for good or evil. The instinct of self-preservation is the most important of all. The leader who ignores this instinct in his subordinates is in constant trouble because it involves all of the questions of shelter, food, pay, promotion and reward. The desire for the security of personal rights in both the leader and the subordinate must be regarded as an offshoot of this instinct.

#### *Group Instinct Betters Race*

The instinct of men to form groups, the associative spirit, like the instinct of self-preservation, is for the good of the race. It leads to the formation of fine associations but also bands men together in cliques and sects and forms cabals. The associative spirit leads to progress in groups of men and to the formation of fine communities of which the hospital is one.

Everyone who works about an institution knows of the reaction of each human being to every other one with whom he is brought in contact. I once knew a man who used to say he could smell a rascal as soon as he entered the room. This man knew nothing of the psychology of instincts but he was referring to this basic instinct of likes and dislikes, of trust and distrust. Properly guided, this instinct leads to group loyalty. Running amuck it is insidious in the extreme.

It is unnecessary to mention jealousy and selfishness, the ancient enemies of races and of men.

Fortunately, the instinct to improve self is as

inherent in men as are some of the baser instincts. This instinct together with the associative spirit, helped by organization, has brought men up from a primitive state to civilization.

It is essential that the instinct to maintain self-respect be not forgotten. Giving reprimands in the presence of subordinates does violence to this instinct.

Everyone instinctively hates inefficiency in other members of his group.

To endow the leader with dignity is another instinctive reaction that needs study in institutions.

It seldom occurs to one that the pleasure obtained from doing good work and also from completing a task are both primitive instincts.

#### *Natural to Select Leader*

It is instinctive for a group of individuals to select a leader. In these days, the leader may exercise control and influence by virtue of his office, but by contact and good will, with knowledge of the instinctive reactions here outlined, he is soon able to take the real position to which he has been appointed. Primarily, the function of the leader is to make decisions and offer inspiration to his group. The member and particularly the leader of a subgroup gains information and formulates programs on the basis of the facts he observes. After the program is formed and the decision rendered the member owes the leader unfailing loyalty in carrying out and interpreting the wishes of the chief. Where individuals are sensitive about being required to follow instead of to lead, they should be reminded that the highest form of leadership is frequently necessary in followers to enable them to influence the leader. A celebrated authority once said of leaders and subordinate chiefs that they must have "practically the same qualities held in different balances. Each tends to counteract the weaknesses of the other and each obtains comfort from the other's strength."

The key word for the leader is decision; for the subordinate leader it is preparation. The leader gives inspiration by showing confidence in his group chiefs. He inspects without spying; he gives his choicest favors to the strong without failing to help the weak; every word of praise and blame is given through intermediate leaders; he is responsible for the selection of the members of his group. The leader must not interfere with details but is responsible for results. He does not lose by listening or by the acknowledgement of mistakes. Lack of decision is fatal. The member is expected to cover the weak points of his leader because the popularity of the chief is of general interest and affects morale.

Even where two men form a group, the relationship should be outlined and the function of each defined. For effective work in larger groups the relations of leaders, subordinate chiefs and members must be clearly stated. The functions of leadership are so delegated, however, in complicated groups that the relationship between leader and follower is often obscured by details. Cutting cross lots leads to happiness if the real significance of group control is not forgotten and the follower remembers that he is acting as agent for the chief and faithfully interpreting his general indications.

The members of the hospital groups having been selected, the leader having been named for each group, their instinctive reactions having been studied, then the plan of organization must be announced. Organization is the lattice work on which individuals and groups may climb. As President Hoover has pointed out in his book on American individualism it is essential that the individual be not only allowed to take the place to which his character and worth entitle him but that he be inspired and stimulated to do so. Without the instinctive desire to progress and the ability to reach his goal, no one can climb on the framework of organization, but if he has all the vigor in the world he will fail without the help of organization.

#### *Organizing a Corporation*

The John D. Archbold Memorial Hospital, Thomasville, Ga., being a new hospital, it was possible at the time of its establishment to take advantage of the good points in organization recently developed in other institutions. The corporation is made up of citizens who make application for membership and who pay a small annual fee and are declared acceptable by the board of trustees. The board in turn is elected, seven members each year, there being twenty-one in all, by the membership of the corporation. This plan assures that the hospital will never fall into improper hands. If the board should ever become narrow or corrupt, an indignant public could soon change its membership. If, on the other hand, the effort were made to gain control of the hospital through the corporation by a section of the public, the board could refuse to accept the applications. The courts could be depended upon, in case of an issue, to decide in favor of the side fostering good public policy.

The board is all powerful as the policy-making body. It has a small executive committee with administrative control during the interim between meetings of the board. Its five standing committees cover every phase of hospital activities but

they have only advisory powers. The chairmen of the standing committees are the only members of the executive committee.

The director is an ex officio member of the board and of all standing committees but not of the executive committee. He is also vested with entire executive control of the hospital, subject only to the executive committee of the board. He has all of the functions of a chief of staff. He is a member of the general staff and of its advisory committee.

The general staff in all of its branches is appointed annually by the board on the recommendation of the medical committee of the board and the staff advisory committee.

The various groups of the staff are represented on the staff advisory committee. The members of this committee are nominated by the groups, confirmed by the whole staff, but are appointed by the board. The staff advisory committee has legislative powers for the staff. The director is its mouthpiece and also may decide whether its actions are in conformity with the policies of the board. It is now intended to give the staff advisory committee judicial power over members of the staff, with the power to hold hearings and admonish members of the staff for violations of professional procedure.

The superintendent of nurses is in autonomous control of the two training schools and is the head of the division of nursing in the hospital. She is an ex officio member, with the director, of the nursing committee of the board. This committee has to do with policy and serious cases of discipline. The nursing committee of the staff which considers professional procedure comprises two members of the staff and the superintendent of nurses. Action by this committee requires approval by the staff advisory committee of which the director is a member. Recently, another committee of which the superintendent of nurses is an ex officio member has been established in the women's board. It is called the auxiliary nursing committee, and has for its functions the consideration of the social life of pupil nurses.

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### Special Baby Clinic Planned for Queensland

A special baby clinic carriage to provide instruction for the mothers in the sparsely settled districts of Queensland, Australia, is being prepared by the government, a report in the *Journal of the American Medical Association* says. The train will have a specific itinerary and will be staffed by two specially trained nurses. The clinic is a part of the Queensland government's baby welfare program.

## Record of Disasters Points to Need for Safely Storing X-Ray Films

**N**ITROCELLULOSE x-ray film in hospitals or where the sick and infirm are cared for constitutes a very serious hazard, a recent booklet issued by the National Fire Protection Association points out. Six institutional fires that were caused in this manner are described.

Where film is mentioned in these fires the nitrocellulose variety is referred to. Safety film, of cellulose acetate stock, is now available and photographically is the equal of the nitrate film. The acetate film has no greater hazard than a similar quantity of ordinary paper. The nitrocellulose film, however, does exist and constitutes a severe hazard unless properly stored. Compliance with the regulations on this subject prepared by the National Fire Protection Association's committee on hazardous chemicals and explosives will do much towards eliminating this particular danger to the sick and helpless.

Details of the six fires listed in the booklet are given here:

*Boston, April 25, 1923.* This fire occurred in the x-ray film storage room in the basement of a hospital. The cause of the fire is said to have been an ordinary electric light bulb that accidentally came in contact with some of the film. Fortunately the basement was provided with automatic sprinkler protection. One sprinkler head opened and promptly extinguished the fire, which otherwise would have endangered the many patients on the floor above. This fire emphasized the hazard incidental to film storage and the value of automatic sprinklers.

### *Films Stored on Wooden Shelves*

*Syracuse, N. Y., September 17, 1923.* Fire occurred in a hospital, starting in the film storage closet in the x-ray room. The x-ray department was located on the first floor, occupying two rooms, with closets and an old bathroom space separating the rooms, and a similar room across the hall used for film developing. The exposed completed negatives, some 12,000, were stored on twelve-inch wooden shelves in the closet and on similar shelves in an adjoining recess without a door, and on three open racks in the operating room itself.

Fire was discovered by a nurse who notified the doctor in the adjoining room. He immediately

came in, opened the closet door, saw the fire burning along the edge of the lowest shelf, obtained a two and a half-gallon soda-acid extinguisher and played it on the flames. This had no effect because, in about one minute, an explosion occurred that threw him about fifteen feet across the room and set fire to the nurse's clothing and hair. This was extinguished by the doctor who then immediately shut the door to the operating room and turned in a fire alarm. The firemen controlled the fire itself within a short time. Prior to this, however, a second explosion occurred, blowing out the windows in the rooms above the x-ray department and bulging the partition to the storage closet in the x-ray department about a foot and a half. This was caused by the gas' going in through the ventilators and blind space, down into the hollow partitions and up through to the second floor igniting when it had obtained the proper mixture.

### *No Definite Cause Ascribed*

No definite cause can be ascribed, but it was probably due to decomposition on account of heat. There was no wiring of any kind in the closet. Two asbestos covered steam pipes passed through it but there was no sign of charring at the floor passage and the pipes were not within one foot of any negatives. The closet, however, was quite hot from the steam pipes. The negatives themselves were in cardboard boxes, in which raw film was received, and were tightly packed on each shelf like books in a bookcase. The doctor's nurse had been filing negatives three-quarters of an hour before the fire and noticed nothing wrong at that time. The damage to the building was mainly limited to inside trim, fixtures and decorations and to the bulge in the partition. The x-ray apparatus was practically a total loss. The films contained in the closet were almost entirely destroyed. Those stored on the racks in the open operating room were apparently undamaged, the cardboard boxes being only slightly smoked.

This fire clearly shows the hazard of storing x-ray films in quantity in buildings of this construction and occupancy without proper vaults. The necessary steps were taken to remove the films to outside storage, limiting the supply to that necessary for one day's use. A fire resistive vault with standard fire door and vent provided

with automatic sprinkler head was also built in the x-ray room to house films.

*Bakersfield, Calif., September, 1927.* A fire in the main county hospital of Kern County, near Bakersfield, Calif., was caused by a careless cigarette smoker. An employee, while at work in the x-ray room, laid a cigarette on the edge of a desk or table. Immediately underneath the spot selected as a good place for catching the smouldering fag was an open drawer filled with x-ray films. It is said that the employee is still a little hazy as to just what happened, but evidently the hot ashes or the cigarette butt itself dropped into the films, causing a flash fire. The heat was so intense and the fire burned so rapidly that damage of approximately \$4,000 to the building and its contents resulted before the flames could be extinguished. About \$1,200 of this loss was on the building and \$2,800 was on furniture and x-ray machinery.

#### *Flames Discovered in Plate Room*

*Chelsea, Mass., February 22, 1928.* Fire was discovered in the Chelsea Memorial Hospital in the plate room of the x-ray department in the basement. The fire, brought quickly under control, caused much smoke, some invading the second and third floors. Newborn babies in the nursery on the second floor were moved by nurses to the nursery cottage a short distance away from the main building. Other nurses quieted the patients. Hospital authorities would make no comment.

*Albany, N. Y., March 17, 1928.* A fire occurred in a small room on the first floor of the Memorial Hospital used for the storage of films and x-ray equipment. In this room, on wooden shelves around both sides and above the entrance, were stored exposed films packed in ordinary cardboard boxes. The cause of the fire is undetermined, although a very thorough investigation has been made by several authorities. No one, according to the best information available, had visited the room within half an hour of the time of the discovery of the fire, and the last employee to visit the room declared emphatically that he was not smoking and that everything appeared to be in order when he left.

Efforts were made by the employees to fight the fire but they were unsuccessful, and fumes from the burning films forced their retreat. In leaving the fire the employees in their haste and excitement failed to close the doors between the corridor leading from the film room and the main hallway in which are the open stairs leading directly to the upper floors. This allowed the smoke and fumes to permeate the building. By this time the

nurses had removed the patients on the floors affected, using the fire escape on the south end of the building and the elevator, which was kept in operation practically throughout the period of the fire. Several patients refused to be moved and in such cases the doors were kept closed and the windows open, with the result that the effect from the gas was almost negligible.

Considerable excitement existed. Many patients were taken from the building by firemen by means of extension ladders, and two persons, a maternity patient on the fifth floor and a student nurse on the fourth floor, jumped into life nets below. Neither of them suffered any serious injury. The nurses in the maternity ward removed five infants and two mothers to safety by means of the fire escape. They endeavored to go back for the other mothers but were not permitted to do so. The press reported eight deaths between the night of March 17 and March 19. It was not possible to find out definitely how many of these were due to the fumes. At least one was due to exposure and heart attack resulting from shock, and it is said that three or four were directly due to the effects of the smoke and fumes from the burning films.

Due to the fire resistive character of the building, the fire was confined to the room of its origin and all the damage was caused by the smoke and gas. Had the door been self-closing, had automatic sprinklers been provided and had there been a proper vent to the outside of the building, it is probable that the entire loss would have been confined to this room.

#### *Fire Starts in Brick Vault*

*Detroit, September 14, 1928.* In the basement of the Delray Industrial Hospital is a brick vault, eight by seven by seven and one-half feet, used for the storage of x-ray film in individual paper envelopes on wooden shelves. An old brick flue extends from the vault to an opening in the outside wall near the second story windows. The vault is equipped with two automatic sprinklers. A nurse, who visits the vault two or three times a week, on recent trips had noticed a distinct odor of camphor and had found the air inside so warm that she had to leave the door open a few minutes before entering.

A half hour before noon on September 14, the fire marshal at a near-by industrial plant was seated in the gate house, less than a quarter of a mile from the hospital. Looking out, he noticed thick, light-brownish fumes escaping from the vault vent. He shouted to others to sound an alarm and raced to the scene. Men had already started to pull out hose and under his direction

quickly had a stream in operation. City firemen coming from their station five hundred feet away soon had another line laid from a street hydrant.

The fumes seemed to envelope the entire building. They also spread up an open basement stairway and penetrated most of the wards, which contained eighty patients in all. A second alarm brought more firemen, to aid in rescue work if the fire should get beyond control. The fumes caused discomfort to some patients, but they were moved to wards on the opposite side of the building, which were carefully ventilated by opening some of the windows, so that no further difficulty was experienced. Meanwhile the firemen were playing two hose streams against the outside of the vault without apparent effect. Then one of the men, wearing a gas mask, smashed the lock on the vault door and threw the door open, noticing at the same time that the two sprinklers inside were discharging water at good pressure. The two streams were then directed inside the vault and soon extinguished the fire.

An unusual condition was the cause of the fire. The hospital is supplied with steam through an underground pipe. This pipe passes near the building wall. Opposite the vault it had rusted through and the escaping steam had dug a channel extending to the corner of the vault where the fire started. Continued heating of the wall soon raised the temperature inside sufficiently to drive off the camphor in the pyroxylin, thus starting slow decomposition. The heat and odor of camphor had led to an investigation and repairs had been made to other sections of the steam pipe, but the serious leak had not been found. Once started, the decomposition gave off heat and this heat further increased the decomposition. Characteristic brownish-white fumes were given off. Finally the ignition point of the gases was reached.

After the fire the contents of the vault were immediately taken outdoors. Only about 15 per cent of the films was found charred. The films left were somewhat scratched in handling. Films and pyroxylin plastic in general, once heated or charred, are rendered chemically unstable and liable to spontaneous ignition, and their prompt removal in this case was a wise precaution.

### Telling the Story of Nursing to the Public

To familiarize the public with the story of nursing is one of the greatest problems before the American Nurses' Association, according to S. Lillian Clayton whose paper, "The American Nurses' Association Today," read at the annual convention of the association is reported in the *American Journal of Nursing*.

"Publicity," says Miss Clayton, "or placing the emphasis upon the various phases of this profession of ours so that it becomes a real educational campaign is one of the needs of our organization. Our director at headquarters has been telling the story of nursing by means of radio talks. She says her story has been the old, old story of nurse, patient, home and the home problems involved, and as a result she knows the public does like nursing.

"There has never been a time when it was so necessary for the individual nurse to be able to interpret her own profession and her place in it, as at the present time. The report just published by the Committee on the Grading of Nursing Schools will help us do this. Let us be responsible for reading this report ourselves, and for giving it to a patient and a doctor. This will be a concrete form of publicity in which we can all help."

### How Canada Is Caring for Its Mental Patients

That Canada is outstanding in the handling of mental cases is shown by the fact that last year 25,000 patients were cared for in the hospitals for the mentally unfit. The number of patients is limited only by the capacity of the hospitals and the money available, and it is estimated that if all cases needing treatment were looked after, another 25,000 patients would be in institutions.

Canada has an investment of \$50,000,000 in buildings for the care of the insane, with an annual maintenance cost of \$9,000,000, according to the *Hospital, Medical and Nursing World*. In connection with mental treatment, the Lady Willingdon fund for research reached \$750,000 last year of which the government and individuals of the dominion contributed \$500,000 and the Rockefeller Foundation \$150,000. This money will be spent in research over a five-year period.

A progressive program has been planned for British Columbia. Similar investigations are being made in Alberta. Alberta has enacted the sterilization law, the first of its kind in Canada, providing for the sterilization of mentally deficient persons discharged from institutions.

### Advantages of the Social Service Department to the Hospital

"Whenever it is practicable and possible, a hospital should have a well organized social service department as an integral part of the organization, and under competent supervision and direction," says Dr. Malcolm T. MacEachern, director, Hospital Activities, American College of Surgeons, Chicago. "I admit that the scientific results of the practice of medicine in hospitals could be greatly improved if these institutions had the advantage of a well organized social service department.

"The department should have at its head a competent trained social worker, approved by the American Association of Hospital Social Workers. She should be directly responsible to the chief executive officer of the hospital. The social service department should be an integral part of the organization just as much as the other essential services—nursing, dietary, clinical laboratory, x-ray—and should be properly correlated with the various units making up the organization."

## *Practical Administrative Problems:* **How to Save Money in the Dietary Department**

By JOSEPH C. DOANE, M.D.

Medical Director, Jewish Hospital, Philadelphia

**D**URING the past months discussions of varied subjects have appeared on these pages. Some of these concerned the theory of hospital practice. Many were of a more practical nature, concretely applicable to the problems daily presenting themselves to the executive. It will be the purpose of this article and of succeeding articles in this department to review some of the points hitherto covered and to stress particularly those that concern the economic conduct of the hospital.

It is the intention, therefore, to make this a practical article dealing largely in generalities because it is not within the bounds of either space or propriety to enumerate successfully too many details.

Many superintendents are confronted from time to time by an intimation, if not by a direct statement from their boards of trustees, that it is costing too much to feed the hospital family. In order adequately to answer this imputation, the executive will want to satisfy himself concerning the efficiency of his food service. In doing this he will have to consider many angles of the problem. Is the food intelligently prescribed? In the hospital, admittedly more than anywhere else, the diet attains not only the place of an agent necessary in sustaining life, it attains also the dignity of a medicine.

### *Cell Nutrition of Great Importance*

True it is that only for a relatively small percentage of ward and room patients are special diets prescribed. It must not be forgotten, however, that in the repair of diseased or incised tissue and in the successful combat with infecting germs, proper cell nutrition is of the greatest moment to the patient's chances of recovery. Hence food partakes of the nature of a remedial agent even though not dignified by the term, "special diet."

The solution to many of the problems discussed in this article lies in securing a trained and com-

petent dietitian and assigning to her the supervision of all the details involved in the purchase, preparation and serving of food. This is the ideal, and many are the dietary officers in the hospital field who are efficiently performing this work. In the presence of such a person the superintendent's task is greatly lightened. But it must be remembered that in a large percentage of the small hospitals in the field lack of funds or the very nature of the institution's organization precludes the possibility of securing a highly trained dietitian. Here the executive assumes many of the duties that in a larger hospital would be apportioned to departmental specialists. Even in the presence of an adequately trained dietetic officer the superintendent should from time to time inform himself of the details in the administration of the dietetic department.

### *Frequent Inspections Necessary*

It is not possible for the superintendent to save food from his office chair. He must from time to time inspect every process in the making of a dietary. He must leave his attractive office suite and journey to the odorous vicinity of the garbage station in order to view end results that will point to the adequacy or inadequacy of the whole food system. There he may learn much concerning whether foods are largely consumed or wasted because, for any one of several reasons, they are unappetizing, or lacking in attractiveness. As he returns to the hospital corridors, often a sadder but wiser man, he undoubtedly will turn over in his mind the question of whether the waste he has observed is necessary and if not who is to blame for it. He becomes more than ever convinced of the truth of the adage, "To save money is to make it," and begins to work out a means of accomplishing both.

There is a type of administrator who treats lightly any suggestion as to the need of scrutinizing details in an attempt to save money. There are others who consider it far beneath the dig-

nity of a hospital administrator ever forcibly to agitate the contents of a garbage pail in order to inspect its contents thoroughly.

To save money is of the greatest importance in hospital work, but efficiency in service to the sick should not be sacrificed. To THE MODERN HOSPITAL, economy in administration does not imply a niggardly or a miserly handling of funds. Nor is it to be inferred that adequate service is not to be rendered even though difficulties are met in making expense and income balance.

Some months ago the functioning of the dietetic department of the hospital was fully described in these columns, and a rather detailed comment was made upon matters of structure and management. There can be no more intimate and practical study made concerning any phase of the hospital's work than that which relates to the purchase, preparation, transportation and serving of food. The quality and size of the hospital's clientele are not infrequently directly affected by the type of food that the institution serves. Even those who patronize ward beds remark upon the high quality of food, or *vice versa*, that they received upon a past visit to the institution.

Hospital food is far from universally pleasing to the institution's patrons. There are many reasons why it is more difficult to please the palates of those who must patronize the hospital, than it is to appease the appetites of those who on a vacation jaunt spend a longer or shorter period in a hotel. The appetite is, after all, largely affected by the state of mind. The vacationist with mind diverted and body rested relishes his food, even though it be of an inferior quality, to a greater degree than does the hospital patient whose mental and bodily structures have been disturbed by disease or by fears aroused by the unusual sights and sounds that surround him.

#### *Food Must Be Appetizing*

Nor is a critical public satisfied with anything but the most appetizing of food in the hospital of to-day. The time has long since passed when food inferior in quality is tolerated by the hospital patron. The dietitian of the hospital, therefore, is asked to prepare food appropriate and pleasing not only to sick stomachs but to personalities that are far from normal.

To save money in the business of feeding the hospital family implies that the diet that represents the end product of the hospital's outlay for raw materials is both adequate from a nutritional standpoint and also correct as a medicine. To meet this dual requirement, raw materials must be purchased economically and prepared, transported and served efficiently.

To save money by the purchase of second grade raw materials, and because of this practice to create dissatisfaction on the part of the hospital's patrons or personnel, is to lose it. If it is granted that the hospital must compete with first-class hotels in the excellence of its cuisine, then it must be recognized that to maintain the approval, respect and patronage of the public, food materials of the highest grade must be purchased.

To nourish the sick man or woman properly requires an understanding of his or her psychology. The patient is not only diseased, he is also away from home. To endeavor to tempt a jaded appetite by adopting the policy of treatment *en masse* is to fail. To meet this difficulty, many institutions in their private and semiprivate departments have adopted the menu plan. To prepare but one kind of meat, vegetable or dessert and then to expect all patients to be fond of this particular type of food is to expect the impossible. Individualization in the feeding of the hospital family is the keynote of successful dietetics, but it is impossible to do more than attempt to attain the ideal that is expected and secured in the family circle.

#### *Meals Not Adapted to Patients*

A visit to a medical or a surgical ward at mealtime is a good starting point to begin this study. Let us then, figuratively, pass down the long aisle that separates the rows of beds in either of these divisions and observe what is transpiring. We come first to a male patient who is recovering from a major operation. His appetite has not completely returned, and yet we find at his bedside a tray upon which are to be found a very large serving of mashed potatoes, a section of beef as large as the palm of one's hand, carrots or beets or peas in such quantity that they have mingled with the other vegetables, a large bowl of soup that has become cool, bread, thickly sliced, and coffee, tea or milk. To the average convalescent the mere sight of such a meal is repulsive.

In the next bed we find a case of malignancy of the stomach with secondary anemia awaiting operation, on whose table a similar tray is vainly awaiting attention. Next we encounter a patient with an infection of the arm, toxic, feverish, unable to feed himself because his right arm is incapacitated, with enough food before him to satisfy the appetite of a plowman.

In the medical wards we note something of the same situation, except that here we find food that is not being consumed because of its nature but with the same defects as to amount. There is a salt free nephritic diet carefully prepared in the kitchen, unappetizing at the best and cold because it has been away from the heat retaining con-

tainer too long. Naturally it is scarcely touched by its owner.

Again one finds a patient actually nauseated, before whom has been placed a diet of the same proportions as those already described. As the observer returns half an hour later, he finds that all evidences of the noonday meal have disappeared from the bedside tables. If he is searching for facts he will visit the ward garbage pail, and there he will find the bulk of what was supposed to be dinner for not a few patients.

#### *Useless From Nourishing Standpoint*

These are occurrences that may be observed in many institutions, not a few of which lay claim to efficiency and thoroughness in the conduct of their scientific as well as their dietetic work. The ways to save money in feeding the hospital family do not concern themselves entirely with the purchase and preparation of food. These are important, but good raw materials, well prepared, are less than useless from a nourishing, medical standpoint if they are not consumed.

In many hospitals this program is repeated in some degree three times 365 times a year and may represent from 10 to 30 per cent of the total food costs. How can such waste be avoided? Instead of proceeding from the kitchen towards the wards, let us reverse the process and see what steps can be taken to fit the food to the patient's appetite and needs. The physician, as a rule, is responsible for the diet of the patient. It is he whose scientific and practical skill is expected to govern the ordering of food that will be appetizing and that will be supplied in quantities sufficient for the patient's needs. If such ordering is incorrect or careless, no matter how excellent the food article, waste will result and the patient will be harmed.

Most staff physicians pay too little attention to the prescribing of diets. This is a matter that is usually delegated to the intern who has observed the sang-froid of his chief so often in regard to matters dietary that he is inclined to set down such prescriptions casually and hence inaccurately. Most staff members are acquainted but hazily with the nature and contents of the hospital's diets. The intern is usually better informed and the nurse, because of her diet kitchen work, is likely to be the best informed of all.

It is often the nurse who is forced to question the advisability of continuing to follow an order for a house diet for a patient whose stomach for a day or more has been rejecting all food. It is the nurse who frequently remarks the persistence of a liquid diet when more food is desired. It is the supervisor of the ward or floor who compiles the number of the various types of diets she requires

to feed her patients. These slips are often so routinized that one or more patients either way appears to make but little difference. The dietitian frequently remarks the unchanging number of diets that are ordered from day to day for the hospital's departments. Patients may be discharged and the same number of diets persist if the order slip is taken at face value. When excessive food is delivered it rarely finds its way back to the diet kitchen.

One solution of the defects in the system, insofar as the staff is concerned, lies in the preparation of a hospital dietary and in a persistent attempt to arouse interest on the part of visiting physicians in its details and in the methods of its application. Too infrequently does one hear a physician ask his patient about his food likes and dislikes. Too often does one encounter a caustic comment by a former patient that food that was to him a poison was persistently served at the hospital. There is but one way to learn of these individualistic phobias and idiosyncrasies, and that is to ask the patient.

Waste in food may be avoided, therefore, at its source—by correcting faulty methods of ordering. In a number of institutions the menu system, in a way, has presented a solution of this problem. But even then, patients are prone to order articles of food in excess of their needs. Moreover, while the private room patient often is adequately compensating the hospital for the expense entailed by his presence, yet the waste of food in the private department is almost as inexcusable as when it occurs in the ward. While it is probably not practical to employ a menu card system for ward patients, yet, in a slightly lesser degree, information can be secured in another way as to the food desires of the patient.

#### *Careless Service Detracts From Meal*

No matter how appetizing the food may be when it reaches the ward unit, this quality may be entirely nullified by inefficient and careless service. One of two general types of service is usually carried out—central service, in which the trays of patients are prepared in a main kitchen and transported to the patient's bedside, or ward kitchen service in which the food is brought in bulk to the division kitchen, and there placed on the patients' trays. The latter type of service will be considered first.

Student nurses are usually delegated to serve the meals of ward patients. In some institutions it has been found practical and possible for a representative from the diet kitchen to perform this work. This is a satisfactory and rather efficient plan. A basic truth in the organization of any hos-

pital division is the desirability for the centralization of responsibility. Proper purchase, preparation and transportation as well as service of food, if assigned to one individual, are much more likely to produce an efficient coordination of effort than is a plan where divided responsibility exists.

As the food reaches the hospital ward, whether it is served from a container that is wheeled into the ward itself or whether the trays are set up in the diet kitchen is of comparatively minor importance. The crux of the situation lies in ascertaining the desires of the patient before the food is brought to his bedside. This may be done by a student nurse or a supervisor, who casually but efficiently interviews each patient as to his food desires for the specific day. Those who are temporarily indisposed are served but the smallest of portions. Those whose convalescence has progressed to a point where a normal desire for food exists are served more abundantly.

#### *Large Servings Often Wasteful*

To heap plates with food, irrespective of the desire of the individuals receiving them is a blundering and wasteful practice. It may be that no special trip to the patient's bed will be required for obtaining this information. When such morning duties as bed making and bathing are being performed, much information can be secured as to the patient's food requirements. A tabulation slip with check columns for designating appetites and food idiosyncrasies may be effectual in the hands of a careful supervisor or head nurse.

Whatever the method, both the quantity and type of food must be fitted to the individual. The prescription must not be *en masse*. If nurses and others could learn early in their hospital careers that wasted food means growing deficits and hampered hospital service, less argument would be necessary.

It is only necessary to mention the attributes of a good tray service for the sake of completeness. These apply to trays that are set before the occupants of the most *de luxe* hospital room, as well as before patients who occupy beds in the most inexpensive ward. Coverings must be clean and bright, if only represented by crêpe paper. The dishes should be hot and not too massive; the food hot and small in amount. The soup should be small in amount, appetizing, not topped by congealed fat or mysterious as to its contents. Bread should be freshly cut, not sliced several hours before mealtime and bisected to represent the whole loaf section. If toast is to be served it must be hot. The world awaits the discoverer of a method of always presenting hot toast to the hospital patient.

Now, it need not be remarked that the dietitian must be thoroughly trained in methods of making food appetizing, but the divided responsibility that often exists defeats the very purpose for which she has striven in the kitchen. If those who are responsible for the serving of food to ward patients could be brought to realize that to be asked for a second serving is a compliment both to their skill and to that of the kitchen workers, and that for the extra steps thus required on their part the hospital is amply recompensed, much strain on the hospital food budget would be relieved.

In central serving the difficulty of individualizing is even greater. Here the intimate contact between nurse and patient is replaced either by a telephone message or by a hurried visit to the kitchen to acquaint the dietitian with the patient's state of appetite for the day. Trays, unless elevator and other physical connections are adequate, are likely to become cold and, hence, the waste of food is increased.

It has also been found in hospitals where central food service is in effect, that much floor space is required in the general kitchen in order that those setting up the trays may have ample opportunity to work about the food trucks. This added expense in construction, however, is somewhat compensated by the lessened amount of diet kitchen and serving room space required on the private and ward floors. Then, too, a much increased personnel is required, which may appear to the casual observer as excessive until it is remembered that those who are working in the kitchen are replacing ward maids necessary when trays are set up on the individual floors.

#### *Many Favor Central Service*

All in all, it seems that there are many arguments in favor of central service—that money can actually be saved under proper conditions by centralizing not only the preparation but also the serving of food and the later washing of the dishes.

From the standpoint of the cost advantages of preparing and serving trays centralization needs no defense, providing architectural devices have been planned to make this scheme effective. But whatever system of serving is used, waste will be avoided if the consumption of food is made more complete by first interviewing the patient before his tray is set before him.

When it comes to the preparation of special diets, much can be said relative to the need for intensive efforts to bring about efficiency. The diet of the diabetic, nephritic, obese or anemic at the best is unappetizing. It is expensive because the weighing of its ingredients and the special

skill required to prepare it, are time consuming. These diets are often but incompletely ingested, and too often much of the work necessary for their preparation is brought to naught because the remnants are not weighed. Here, as in any other type of dietary effort, careful preparation, transportation and serving are necessary. These diets must be presented to the patient in small quantities and in as great variety as is consonant with the scope of the specific diet.

#### *Avoid Machinelike Diet Prescriptions*

Much has been said concerning the necessity of avoiding the machinelike prescription of diets. The distance between the ward and the diet kitchen must be lessened administratively if not physically. The work of the dietitian must be more actively integrated with that of the ward and private floors if good food service to patients is to be given at the least possible cost. Too frequently one fails to observe the presence of the dietitian beyond the confines of her kitchen and classroom. A closer contact with doctors, both visiting and resident, with nurses and with others who are actually caring for patients should serve to acquaint the dietitian and her assistants with the faults in food service that are observed at the point of consumption.

To buy good foods, to prepare them properly, but to fail to have such dietary medicaments actually consumed and assimilated by those for whom they are intended is to waste money shamelessly. Closer cooperation, therefore, between the personnel of the dietary department and that of the wards, either by the former visiting the latter, or by visiting physicians consulting the dietitian in her department, is productive of efficiency and of economy in the use of food articles.

In feeding hospital patients, it is always found to be a long, long way from the kitchen to the wards when it comes to the transportation of food. If the central service system is in effect and the hospital has been constructed with this in view, special types of vertical or even horizontal transportation equipment avoid deterioration of food in transit.

If central service is not employed, some type of heat retaining container must be used. There are many of these upon the market, some depending upon insulation with wool, felt, asbestos, cork or other types of nonconductors, others upon the heat retaining qualities of water and, finally, those electrically heated and so arranged that they may be placed on an electric circuit as soon as they reach their destination.

Many of these trucks are efficient and practical, but many also are cumbersome, too heavy and not

useful for bedside service. Whatever type of transportation is employed, the end result—hot food—will speak for itself. No apparatus is efficient unless there is a trained personnel to use it. The carelessness of those who serve food to the sick often brings about criticism of the hospital and, even more frequently, waste of money.

It appears well at this time to make some statement concerning the details of building a menu. Irrespective of faults of service, transportation or preparation, there are some attributes of a hospital menu that are too infrequently considered. It must possess variety. Of all the complaints one hears in both private and public wards, that which relates to the dreary regularity in the serving of certain foods is the most frequent. If the dietitian does no more than attempt to create the agreeable sensation of surprise that is observed when an unexpected article of diet is placed before the patient, she will have accomplished much. To have, for example, beef or mutton on Tuesday, fish, always prepared in the same way, on Friday, and chicken on Wednesdays and Sundays, is to lay the foundation for a dietetic monotony discouraging both to the patient's appetite and to his morale. Many a distraught dietitian, confronted as she is with duties that should not pertain to her office such as the preparation of luncheons for ladies' boards or even for guests of the superintendent, has little time left to consider the psychology of the sick man or woman.

#### *Dietitian Needs Standard*

Granted the necessity for variety, for daintiness of service, for excellence of quality of food products, how can the dietitian be given some standard by which she may govern her expenditures? Many a superintendent has learned to his surprise and alarm that in the course of a month, or even over a greater period of time, he has exceeded his food allotment by many hundreds or several thousands of dollars. It is unfair to take the dietitian to task for this occurrence. The superintendent must devise means whereby he, theoretically at least, places in the purse of the dietitian a definite amount of money with which to purchase raw supplies.

If a central storeroom is in use, all food products are placed in it. The dietitian, in building her menu, is acquainted with the unit costs of the articles she intends to use. The cost of her staples may be easily computed. In ordering green goods, fruits and even unusual and expensive meat articles, she is first informed as to the amount of money she is allowed to spend per meal, per day or per week. She is acquainted with the number of persons she must feed. She computes the cost

of articles she is about to requisition from stores. She then is able to decide what type of extra or unusual and, hence, relatively expensive food she can afford to buy. If, on a given day, for example, she has been able to prepare her menu at a cost below that which she is allowed, she may purchase on a succeeding day in excess of her allotment for this period.

She keeps a daily expense sheet and she sets down the cost of articles withdrawn from stores, such as potatoes and other vegetables, milk, butter, eggs, canned goods, relishes and the various other standard articles of food that she requires. She finds from experience or from actual computation that she is able to buy out of season foods such as strawberries or asparagus or string beans at a cost that still enables her to spend no more than is, figuratively, in her purse for that day. At the end of each day's work she is able to compute, and should do so, the exact cost of feeding during the last twenty-four hour period the various classes of hospital persons, such as patients, nurses, doctors and help.

#### *Biweekly Conference Urged*

There should be at least a biweekly conference of the dietitian, purchasing agent, superintendent and perhaps the directress of nurses concerning the kinds of articles the dietitian is allowed to use in making her menu, and whether the food that is being served represents a properly balanced diet. In this way, a hospital director may so budget his food expenditures that he is able to prevent a deficit before it occurs. For example, if an annual budget for food for a small hospital is \$200,000 a year, it is easy to estimate that approximately 25 per cent, or \$50,000 a year, will be necessary to buy food. The cost of preparing and serving this food may vary from 3 per cent to 5 per cent of the total food expenditures. This latter estimate is subject to much variation and is dependent, of course, upon the type of organization in the dietary department, the kind of service employed and the efficiency with which either of these schemes is carried out.

The test of the whole system lies in the results of the inspection of the garbage pail. It has been said that the most expensive article of equipment in the modern hospital, is this apparently cheap article. Some executives are of the opinion that the inspection of garbage, its careful weighing, and a computation of the ounces of waste per patient are not of great importance. It appears, however, that much information is to be secured from these procedures. The dietitian, or her assistant, should as regularly inspect the refuse coming from the wards and rooms as she does her ice boxes.

Where such food articles as bread or peas or potatoes or meat are repeatedly found in the garbage pail, there is something radically wrong with the service, the transportation, the preparation or the purchase of the food. It is surprising what a healthy degree of competition can be generated at the weekly meeting of supervisory nurses at which a comparative statement of ounces per capita of waste in each department is read.

To inspect and weigh garbage properly, a central storage plant is necessary. Here can be placed a live steam jet for can sterilizing, scales for weighing and closed cement or steel boxes for the proper storage of garbage cans until their contents can be removed from the premises. For each department there must be properly stenciled cans. In some hospitals orderlies or floor men have been known to dump the garbage of their departments into the pails of another to prevent per capita waste rates from rising. If a department shows twelve ounces of waste per patient it is time for the dietitian to make a survey of this department to learn the cause for the excessive waste. When this waste is below five or six ounces per patient, something may be just as radically wrong. Garbage inspection may reveal that details such as the methods employed in the slicing of bread, the preparing of fish or of vegetables are faulty.

One way, therefore, to save money in every hospital is to supervise carefully the end results of the work of the dietary department. This supervision may begin as well as end at the garbage station.

In a subsequent article, practical methods of saving money in the purchase and preparation of food will be discussed.

### Functions of the Social Service Department

What are the functions of the social service department of the hospital?

According to Dr. Malcolm T. MacEachern, director, Hospital Activities, American College of Surgeons, Chicago, the primary function of the department is to assist the doctor in the scientific care of the patient through medical social case study, requiring the assembling, analyzing and evaluating of all data obtained for the purpose of working out a proper medical social plan correlated with diagnosis, treatment and follow-up. The secondary functions are to assist the administration of the hospital to understand better the social aspect of the patient, to induce the patient to take treatment better, to relieve the patient and family of physical and mental worries, to cooperate with public health, welfare agencies and official groups in promoting better community relations and to cooperate with schools of nursing and universities in the education of the student nurse and social worker.

# Editorials

## Lessening the Explosion Hazard by Reducing Film Storage

THE Cleveland holocaust brings forcefully to our minds the potential danger in the handling of x-ray films. We must, however, keep our feet firmly on the ground and not permit this disaster so to sway us that we shall incur unnecessary expense without finding any solution to our x-ray film problem.

At the same time, this disaster should emphasize in our minds that the storage of x-ray films has a potentiality for danger that cannot be exaggerated. No one method of approach to the problem is a panacea. Fireproof vaults, so-called safety films, fireproof cabinets, sprinkler heads, the elimination of smoking, the elimination of extension cords and the closing of existing electrical outlets in vaporproof globes all are desirable, but unless we adopt the policy of discarding unnecessary films quickly we shall produce a volume of film storage that in itself is a definite menace.

It is not suggested that essential films be discarded, but unquestionably negative films of certain types should be discarded on thirty-day periods. Master films may be made of other types of exposures, and with the right attitude on the part of the personnel of the roentgenological department we can reduce the volume of films that are to be stored to approximately 25 per cent of the volume produced in the laboratory.

This is the experience of many successful x-ray laboratories and seems to offer the best possible solution to the reduction of a definite menace.

## Drug Addiction Colonies

THE control of drug addiction has become a more and more pressing problem in recent years. Long before the passage of the Harrison Anti-Narcotic Act, it became evident to those who looked into the matter that repressive measures must be taken for the protection of the public health and the economic welfare of this country.

The enactment of federal legislation has made it more difficult to secure narcotics but at the same time has made narcotic bootlegging infinitely more remunerative. Drug trafficking has therefore increased enormously and there is scarcely a city in the United States that does not have its well organized coterie of drug peddlers.

Until its use was prohibited, heroin contributed enormously to the annals of crime and after its use had passed, the introduction of marijuana and pelote further complicated the problem. An attempt was made to make drug bootlegging unprofitable by the establishment in several states of drug dispensaries where, at a nominal cost, addicts could obtain their daily dosage. This resulted in many abuses and these institutions were closed by an order from the federal government.

It became increasingly evident that some means must be provided for the treatment of persons addicted to the use of drugs, and at several of the federal penitentiaries, these unfortunates are being given treatment under adequate medical supervision. A surprising number of persons requested admission to federal penitentiaries for the purpose of receiving this treatment. In order that this might be done, it was necessary that an indictment be drawn up and the person committed as a criminal.

A number of persons led by Representative Porter of Delaware came to the conclusion that this method was unsatisfactory because at least 10 per cent of the persons so treated were found on readmission to the penitentiary to have gone back to their old habits. It was seen that the withdrawal of the drug and the return of the addict's body to a relatively normal condition were insufficient and that to be successful, treatment must be supplemented by social rehabilitation, education and good character formation. Furthermore, it was felt that the atmosphere of penitentiaries was not conducive to the best results and that in such places it was almost impossible to prevent drug trafficking.

On January 29, 1929, the President signed an act providing for the establishment of two farms for the treatment and rehabilitation of drug addicts. This act also took cognizance of marijuana and pelote as habit-forming drugs. This was most important because in the extreme South and Southwest these two drugs are creating great havoc, particularly among the Negro and Indian population. The act referred to is an enabling act and it will be necessary for subsequent congresses to make appropriations adequate for the erection of the contemplated institutions. Interviews that recently appeared in the public prints indicate that between seven and one-half and ten million dollars will be required for the initial outlay. These farms will contain adequate means for the treatment, care, rehabilitation, recreation and education of the inmates. Voluntary commitment is provided for by the act which also makes provision for paying inmates for useful work that they perform. Very wisely, the responsibility

for the operation of these institutions has been placed on the U. S. Public Health Service.

This is a public health problem of the first magnitude which affects the entire nation. Every drug addict is a carrier, because the psychology of the disease is such that every addict tries to make new addicts. The law also provides for the establishment of a new division in the Bureau of the Public Health Service to have charge of the battle against narcotics, and already an officer of the Public Health Service is making a survey of the United States to determine the extent of the problem and the manner of its humane solution. This is a noble social experiment and deserves the aid of all who are interested in the welfare of man.

### A Fitting Memorial

A CONTRIBUTION of \$1,000 has been received by Stanford University, San Francisco, to start the Brodrick Memorial Fund in honor of the late Dr. R. G. Brodrick, physician superintendent of Stanford University Hospitals, and formerly president of the American Hospital Association.

The income from this fund is to be used for clinic free beds. The wisdom and propriety of such a memorial are too obvious to require further comment. It is exactly the sort of thing that Doctor Brodrick would have approved for the memory of someone else. Further contributions to this fund will be gladly received in any amount, and should be sent to Dr. William Ophuls, dean, Stanford University Medical School, 2398 Sacramento Street, San Francisco.

### A Staff Duty

THE private room department of the hospital when well filled is the source of much gratification to the superintendent and of not a little income to the hospital. Unoccupied rooms, on the other hand, are productive of sleepless nights to superintendents and of disturbing deficits. Yet the hospital does not have at hand any efficient ethical way of increasing the use of these facilities.

In the last analysis, staff physicians are the logical salesmen of the hospital's private accommodations. It is usually the doctor who suggests the advisability of hospital treatment and who, in a degree at least, determines the type of room the patient is to occupy. If the physician is alert to the best interests of the hospital and of his patient he will inform himself relative to hospital room rates and accessory charges for laboratory, x-ray

and other diagnostic or therapeutic services. Too often unnecessary and unfair criticism is directed at the hospital by disgruntled patrons who are disagreeably surprised at the size of their bills and who should have been informed by their physician prior to admission relative to room rates and other hospital charges.

The board of trustees of a hospital is perfectly justified in looking to staff members to maintain a high percentage of occupancy in the private department. The time is fast approaching when the collector of staff positions must be required to relinquish those that he cannot properly fill and asked to center his professional attention on but one or two at the most.

That there is no standard of practical support which the hospital should require from the staff physician is to be regretted. It has been said, however, that during the term of duty of a physician and surgeon, the major portion of his private work should be sent to the hospital where he is serving. Even this is but an ineffectual attempt to measure staff responsibility from the economic aspect. Other factors enter into the problem but cannot be discussed here.

To furnish good hospital ward and room facilities is the plain duty of a board of trustees. To require that staff physicians use them for the treatment of their patients is just as certainly both a right and an obligation on the part of the board.

### Talking It Over

NEVER waste time trying to demonstrate to other people what a good piece of work you are doing. If the accomplishment isn't good enough to speak for itself, it isn't very good. Nobody ever got far by continuously telling the boss what splendid work they were doing. If the work is well done, the boss will find it out and appreciate it. The reverse is equally true.

\* \* \*

NOT by what we could do,  
Not by what we would do,  
Not by what we should do,  
But by what we do do,  
Are we judged.

\* \* \*

THINK out what you want to do; work, work, work at it; concentrate on your objective; devote yourself to it wholly and you will surely win. This is the only formula of success.

\* \* \*

LET the surgeon be well educated, skillful, ready and courteous. Let him be bold in those things that are safe, fearful in those things that are dangerous, avoiding all evil methods and practices. Let him be tender with the sick, honorable to men of his profession, wise in his predictions, chaste, sober, pitiful, merciful, not covetous

or extortionate, but rather let him take his wages in moderation, according to his work and the wealth of his patient, and the issue of the disease and his own worth." So wrote Guy de Chauliac in 1363 and it is an admonition befitting at all times, applying not to surgeons alone but also to the entire hospital field.

ADMIT your error and when you say you are right, you will be believed.

LOT of people who advertise themselves forget that they must deliver satisfactory goods to the customer if they are to have return sales.

DID you ever stop to evaluate the so-called hygienic truths that we are feeding to the general public? Did you ever ask yourself seriously what scientific basis exists for many of these teachings? For example, "Take a bath every day." Is it well proved that the daily bath is absolutely essential to life? There are many races who never get wet in their lives unless they are caught out in the rain and yet who live to ripe old age. "An apple a day keeps the doctor away." Is this literally true? "Always sleep in the open air." If this were necessary to the prolongation of life, many of the countries of Europe would now be depopulated. "A clean tooth never decays." We all know that this isn't accurate and, conversely, that there are many people who have never owned a tooth brush or practiced oral hygiene who die at a ripe old age with a complete denture. "Eat a baked potato every day." Anyone who has ever studied potato-fed children knows that such a doctrine is wholly pernicious, unless the diet is balanced by proteids. That there is a certain kernel of truth in all these statements cannot be gainsaid but in our enthusiasm for personal hygiene, we have adopted too many catchwords and too few well authenticated facts. We need a little more of the sub-junctive in our sanitary slogans. "Don't Spit. To Do So May Spread Disease," is accurate because it states the fact clearly but not dogmatically.

THE Æsclepiadae maintained at various places in ancient Greece shrines where people went to be cured of their various ailments. Athens, Kos, Knidos and Epidaurus all maintained famous resorts of this sort. They were more or less similar in having a temple, an altar of sacrifice and a more or less open portico, called the "abaton," where patients spent the night. That there was a certain amount of hocus-pocus surrounding the treatment is evident from a satirical passage in Aristophanes' play, "Pluto." The slave, Karion, describes what took place when his blind master, Plutus, was taken to the temple of Æsculapius in Athens. This probably is more or less of a caricature of the usual methods employed but like most caricatures it has a considerable resemblance to the truth:

"FIRST we took him to the sacred spring and washed him; then we entered the precinct of the god, and after offering cakes and other preliminary sacrifices, we duly put him to bed, among a number of others suffering from divers diseases, and we ourselves had shakedown beside him. Then a minister of the god came in and put out the lights and bade us go to sleep, and keep silent if we heard any sound. So we all lay quiet. But I could

not get to sleep, and I saw the priest going round the sacred tables and altars, picking up the figs and cakes and consecrating them into a bag.

"THEN the god appeared, accompanied by his two attendant maidens, Iaso and Panacea. I hid my head under my cloak in fear, but I watched through the holes in it. And I saw the god going the round of the cases in due order, and an acolyte set beside him a stone pestle and mortar and a medicine chest. He first approached Neoclides, a blind man who excels those who can see at thieving, and he mixed and ground an ointment for him of garlic and fig juice and squills with vinegar, and anointed his eyelids, turning them back to increase the smart. And the patient shrieked and cried out and tried to run away; but the god laughed and told him to sit still with his plaster.

"THEN he came to Plutus and sat beside him, and first he felt his head, then he took a clean napkin and wiped his eyelids; and Panacea covered his head and face with a purple cloth. Then the god whistled and two enormous snakes issued from the temple and gently crept under the cloth, and as it seemed to me, licked round his eyelids; and immediately Plutus stood up with his sight restored; and I clapped my hands for joy, and the god vanished with his snakes into the temple. And those who were lying beside Plutus congratulated him and remained awake all night till dawn."

A MULTIMILLIONAIRE automobile manufacturer told this story: "After I had been working for about six months on my first automobile job, I asked my foreman how much of the company's stock he owned. He was firmly convinced that the corporation wouldn't last six months and didn't hold a share. I always hated the idea of working for somebody else so I saved and bought a few shares, to which I added as rapidly as I could. Finally I held quite a block. Some I bought as low as six; the average price was nine. That stock has been split six times and is now selling at 115. Before the end of the year, it will be 200. I've made money in other ventures but always by having faith in them, too."

JUST how much stock do you hold in the organization with which you are associated? Just how much real faith have you in it? Do you have the "won't last six months" attitude to it or do you genuinely believe in its purposes and ultimate success? As you work, do you feel that you are "working for somebody else" or do you realize that every day's good work for the institution is two days' good work for yourself?

HOSPITALS, as a rule, don't have stock in the sense of beautiful examples of the lithographer's art. Nevertheless, every worker therein may purchase, by the expenditure of heart, head and effort a big block of the hospital's spiritual copartnership, which will be "split" many times and which declares soul-satisfying dividends at frequent intervals.

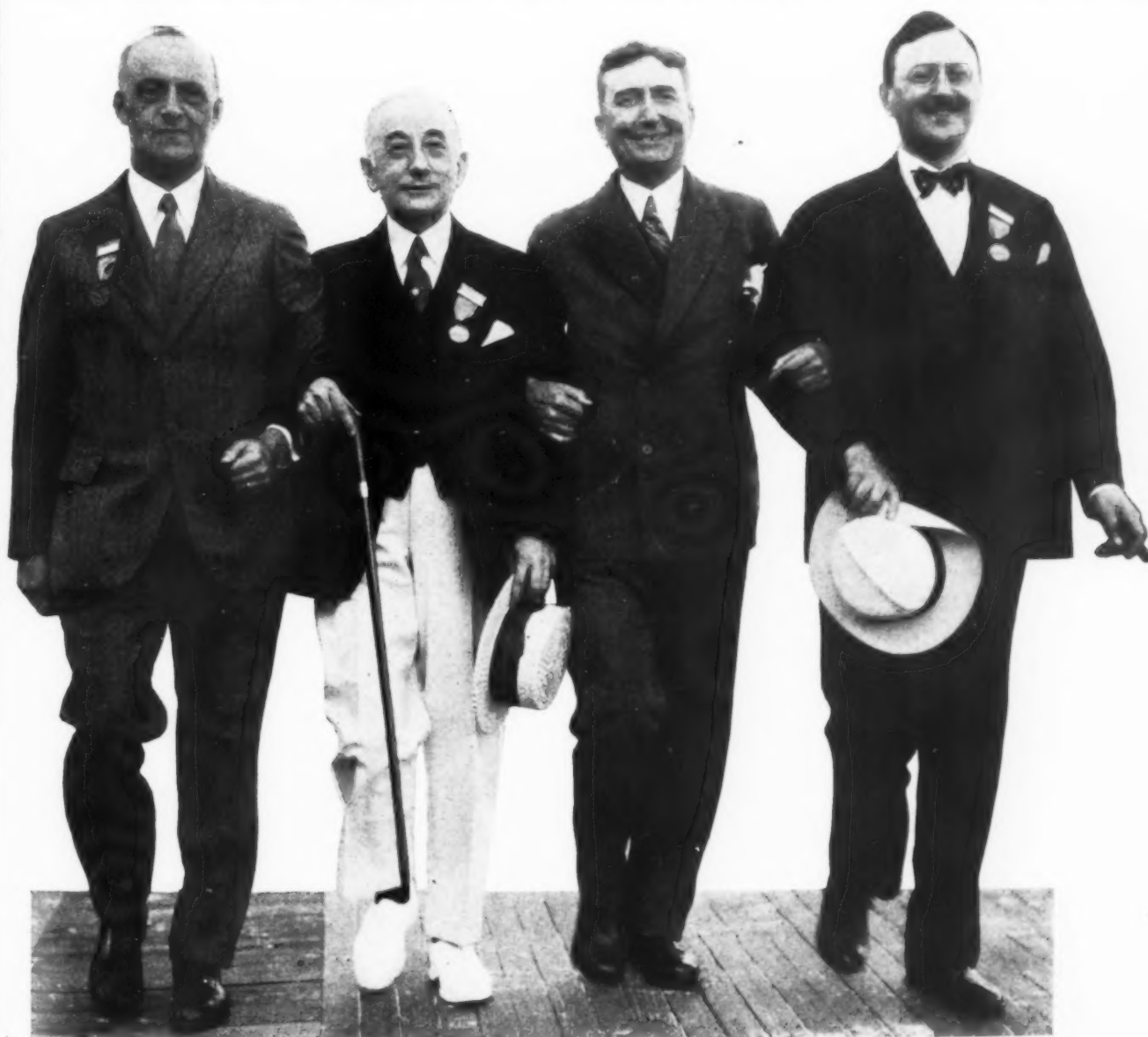
IT'S a matter of faith. Faith in the organization so that you will feel that whenever you increase the hospital's good name, you will add lustre to your own. Faith in its purposes so that when you labor in their fulfillment, you will feel that you are working for yourself. This is the way to become a multimillionaire, spiritually.

## Comprehensive Program Marks International Congress

THE first International Hospital Congress held June 13 and 14 at the Ritz Carlton Hotel, Atlantic City, N. J., proved to be of epoch-making proportions. Seldom has such a comprehensive and enlightening convention been held and it has been remarked by many who were present that this occasion will be one of important influence upon the health of the entire world.

In the August, 1926, issue of THE MODERN HOSPITAL appeared an editorial urging the support

of an international congress, a movement then being advocated by Dr. E. H. Lewinski Corwin, New York, and others who had had contact with European hospitals. The matter was taken up and discussed at two meetings of the American Hospital Association. At that and subsequent times its success was in doubt but it was considered worth the effort and a committee was appointed consisting of Dr. S. S. Goldwater, New York, Dr. Joseph C. Doane, Philadelphia, and



*Dr. S. S. Goldwater, Dr. Walter H. Conley, Dr. René Sand and Dr. E. H. Lewinski Corwin.*

## *A Message From René Sand*

**F**OR a foreigner the multiplicity of organizations existing in the United States is incomprehensible as long as he fails to realize that they are stimulated and coordinated both by permanent agencies and by annual meetings that bring together a great number of those interested in the various movements.

In the hospital world the great difference between America and Europe lies in the fact that in America many of the best institutions are private and at the same time have a more complex organization than have the hospitals in other parts of the world. These conditions, as well as the admirable spirit of service displayed by the administrative, medical and nursing staffs of the American hospitals have led to the creation, thirty-one years ago, of the American Hospital Association which for the first time in the history of the world has gathered on international lines all those interested in the progress of hospital work. By their constant and devoted efforts the members of the association have not only advanced the American hospitals from the point of view of the comfort and welfare of the patient but they have also set an example that has been followed by other nations. The Belgian Hospital Association, for instance, was created last year on lines exactly similar to those of the American Hospital Association.

The International Hospital Congress, which gathered on the initiative of the American Hospital Association, will lead to the creation of such national associations in many more countries and will in this way enable the whole world to participate freely in improving hospital service to the sick.

It is indeed an extraordinarily gratifying sight to see hundreds of hospital executives, physicians, surgeons, nurses, social workers, occupational therapists, dietitians, technicians, architects and others pooling their experiences and giving their best to raising the standards of hospital service. The patient care regarding details, the scrutiny of administrative methods, the constant search for improvement cannot fail to impress deeply any visitor who realizes the amount of self-sacrifice that these studies require from those who preside at the various meetings.

We have here illustrated in the most striking way two of the greatest forces of American life—the inspiration of a high purpose and the spirit of cooperation, which are the main conditions of progress. Any outsider who looks amazed at the success American hospitals have attained will find in these two factors the explanation and the key.

*Dr René Sand*

Doctor Corwin. This committee met with representatives from many of the European countries in Paris and at the Minneapolis meeting of the American Hospital Association it was announced that arrangements had been made for an International Hospital Congress to be held in America in 1929.

That such a congress would attract hospital men from nearly thirty nations of the world and that the meetings which were held at the Ritz Carlton would have a registration of 114 was scarcely dreamed.

The delegates arrived in this country about June 5 and entertainment for them started immediately with a dinner given at the New York Academy of Medicine. Many prominent medical and hospital officials appeared on the program. Preceding the dinner the visitors inspected New York hospitals, notably the Columbia-Presbyterian Medical Center, and the hospitals of Westchester County, including Grasslands Hospital, Valhalla, Bloomingdale Hospital, White Plains, and the Burke Foundation.

This trip was made under the auspices of the New York City hospital superintendents. Following the Academy of Medicine dinner all of the delegates, under the guidance of Dr. Walter H. Conley, general medical superintendent, department of hospitals, New York City, a trustee of the American Hospital Association and an official delegate from America to the congress, boarded a boat for Boston where they were met by a committee headed by Dr. Frederic A. Washburn, director, Massachusetts General Hospital, Boston. In Boston visits were made to the Boston City Hospital, the Forsythe Dental Clinic, the Harvard Center and the State House where the men were received by the governor of Massachusetts and the mayor of Boston. Luncheon was enjoyed at the Massachusetts General Hospital.

The next city visited was Montreal where Dr. A. K. Haywood, superintendent, Montreal General Hospital, met the delegates. Visits were made to Notre Dame Cathedral, several of the

hospitals, the city hall and finally to the St. Denis Club for luncheon, where several addresses of welcome were given.

Because it is one of the wonders of the world, Niagara Falls was the next stop. Here the delegates stayed over night and enjoyed the illumination of the falls.

At Rochester, N. Y., Dr. C. G. Parnall, director, Rochester General Hospital, Dr. N. W. Faxon, di-

rector, Strong Memorial Hospital, and other Rochester hospital men met the visitors and escorted them to the Eastman Company, the Bausch & Lomb factory and several of the hospitals. Luncheon was served at the Rochester General Hospital and tea at the Genesee Valley Club.

The capital of the United States, Washington, D. C., was the next city in the itinerary and here the Capitol Building, the Congressional Library, the Bureau of Engraving and the grave of the Unknown Soldier were visited.

Baltimore and Johns Hopkins Hospital received the next visit.

Dr. Winford H. Smith, director, Johns Hopkins Hospital, met the delegates, all of whom were greatly impressed by this world-famous institution.

The last city to be visited was Philadelphia, where the delegates were met by a committee headed by Doctor Doane. Busses were provided for a general inspection of hospitals and other points of interest, the tour ending at the Bellevue Stratford Hotel for a banquet given by the hospitals of Philadelphia. Doctor Doane presided and speeches were made by the president of the Association of Commerce, Philip Gadsden, Dr. Wilmer Krusen, former health officer of Philadelphia, Dr. René Sand, technical counselor of the League of Red Cross Societies, Paris, and Dr. Walter Conley.

Because of the fine hospitality and the excellent service Doctor Conley has provided for the delegates, they presented him at this time with a beautiful silver platter. Dr. J. P. Kinloch, chief medical officer, Department of Health, Edinburgh,



Dr. René Sand.



*Between sessions delegates enjoyed strolling along Atlantic City's famous board walk. At the left are representatives from Holland, Finland, Poland and Germany.*

*Seven countries are represented in the group at the right. These men traveled to the convention city from Holland, Spain, Brazil, France, Italy, Belgium and Denmark.*



*And at the left is another sextet stepping briskly along the walk. Most of the men in this group are Americans, coming from many parts of the country.*

*The English delegates at the right gave their "home towns" as London, Chester, Wolverhampton, Derby and Suffolk.*



Scotland, made the presentation speech. Doctor Sand was also presented with a platter in appreciation of his fine work and untiring efforts in making the congress a success. The presentation speech was made by J. E. Brizon, president, Hospital Federation of France, Lyons.

The party then proceeded to Atlantic City, arriving late on June 12.

Upon motion of Doctor Conley, Doctor Sand was made temporary chairman of the meeting. Doctor Corwin acted as secretary. The first paper presented had been prepared by Dr. John A. Hartwell, president, New York Academy of Medicine, and was read by Dr. Charles Gordon Heyd, professor of surgery, New York Post Graduate Hospital. It was titled "Essential Hospital Functions."

"It is the central idea that the hospital is primarily a conserver and a restorer of health and that the care of health is its paramount responsibility which gives to the hospital the atmosphere that is so evident as the breathing spirit in our first class institutions," declared Doctor Hartwell. "Only insofar as the hospital fulfills this function does it fulfill its obligation to those who, by their generosity and foresight, whether these be private individuals or the state itself, have made the hospital possible."

He then outlined the broad functions of American hospitalization in which not only the poor but the rich and moderately well-to-do receive benefits from these institutions and by so doing help each other.

The paper was discussed by twelve of the delegates, bringing to the meeting many interesting phases of foreign hospitalization. Many of the discussants spoke in French, German or Spanish and Doctor Sand most capably gave to the audiences summaries of the speeches in two languages other than that used by the speaker.

Two papers were read in the afternoon, the first by Dr. S. S. Goldwater on "Economic and Administrative Aspects of Hospital Planning" and the second, "Problems of Hospital Economics," written by Dr. Julius Grober, University of Jena, Germany, and read by Dr. J. Wirth, Frankfurt, Germany. Both papers were thoroughly discussed. Doctor Goldwater's paper will appear in the August issue of THE MODERN HOSPITAL. Doctor Grober summarized his remarks under the following headings: hospital ownership, economic problems in their relation to real estate and buildings belonging to the hospital, economic problems of hospital administration, purposes and aim of hospitals, reduction of expenses, increase of income and relation to public welfare. He based his remarks upon a study of hospitals made in central Europe, Turkey, two South American countries and the eastern states of the United States.

The third paper read was by Dr. W. H. Mansholt, director, Municipal and University Hospital, Groningen, Holland.

Doctor Mansholt's topic was "Respective Fields of Public and Private Hospitals" and after discussing what shall be termed public and what pri-



*Dr. Bert W. Caldwell, Dr. S. S. Goldwater, Dr. E. H. Lewinski Corwin, Dr. Walter H. Conley and Asa S. Bacon.*

vate hospitals he gave the results of a survey of hospitals in many of the European countries and quoted the figures for the United States from **THE MODERN HOSPITAL YEAR BOOK**.

Dr. Julius Tandler, commissioner of health, hospitals and public welfare, Vienna, Austria, presented the next paper entitled "Hospitals for the Chronically Afflicted" and many interesting discussions arose from his remarks.

Dr. George W. Henry, director of laboratories, Bloomingdale Hospital, then presented a paper on "Psychopathic Hospitals." Doctor Henry told of the development of mental hospitals and also of the development of more humane treatment for insane patients.

The last order of business was the presentation of the report on the creation of an international hospital association.

This was given by J. E. Brizon, France, and A. Gouachon, secretary-general, Hospital Federation

of France, Lyons. The report was a most comprehensive resumé of hospitals and hospital associations in all of the countries that would enter into an international association.

At a business session of the congress Dr. René Sand was retained as temporary chairman and Doctor Corwin as secretary-general and it was decided that those present, upon returning to their respective countries, should enlist their hospital associations or governments to take official action on the formation of a permanent association. It was tentatively agreed that the next meeting be held in Vienna in 1931.

Credit for the excellent program goes to Doctor Goldwater, credit for the carrying out of that program goes to Doctor Sand, credit for the excellent spirit of fraternity goes to Doctor Conley and, finally, credit for the success of the first congress unquestionably goes to Dr. E. H. Lewinski Corwin.

## Annual Hospital Convention Proves Outstanding Success

FROM every standpoint the thirty-first annual meeting of the American Hospital Association proved the outstanding success in the history of American hospitals.

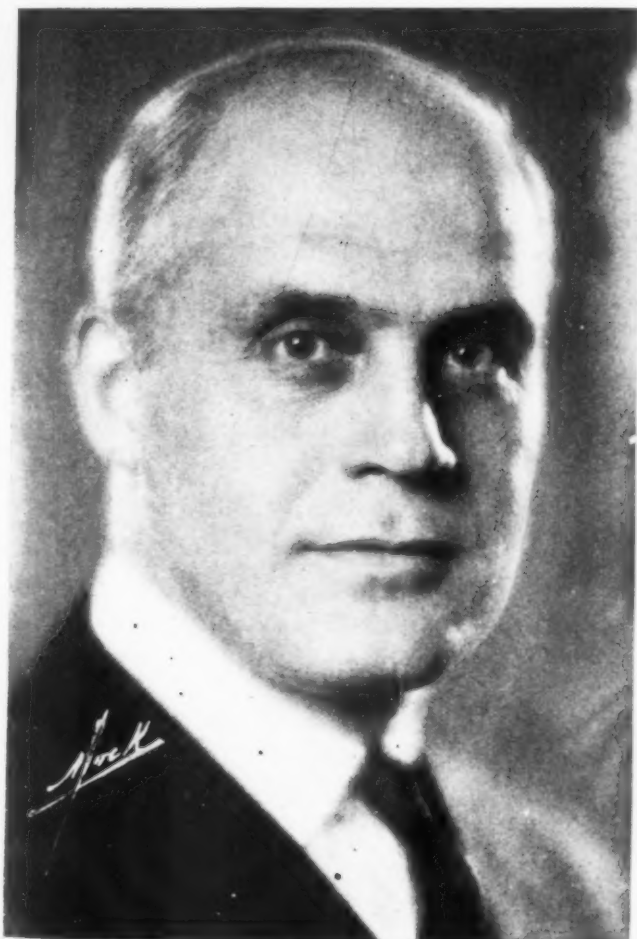
The attendance, exceeding 2,800, the hall in which the meeting was held, the programs of the hospital association and the other associations meeting, the spirit that pervaded the assemblage, the ideal weather conditions and last but far from least important, the management of the meeting—all were ideal and reflected great credit upon Dr. L. H. Burlingham, president, and Dr. Bert W. Caldwell, executive secretary of the American Hospital Association, who carried out the gigantic task with equanimity and calm.

The new auditorium at Atlantic City where the exhibit and meetings were held is the largest

structure of its kind in the country. No description would be adequate to impress those who have never seen it. In its large general hall was held the exhibit of educational and technical displays and the broad aisles were a joy to those attending. The lighting and ventilation seemed to be perfect and the hall at all times was comfortable despite the extreme heat that caused some discomfort on the board walk.

The presence at the meetings and in the exhibit hall of the foreign delegates to the International Hospital Congress added greatly to the success of the meeting, as did the meeting of the National League of Nursing Education which held some of its sessions with the American Hospital Association and some of them separately.

Both the reception on Monday evening and the



*Dr. Christopher G. Parnall, who takes office as president of the American Hospital Association.*



*Dr. Lewis A. Sexton, chosen at the convention as president-elect.*



*Dr. S. S. Goldwater.*

banquet on Wednesday evening proved exceptionally interesting features. The Monday evening reception and introduction of foreign delegates and the presidential address by Dr. Louis H. Burlingham were impressive and bespoke the excellent preparations made for the occasion. Nearly all of those who came from overseas attended this reception and mingled with the delegates from the United States and Canada with the feeling of fraternity and common interest that marked the entire convention. Doctor Burlingham delivered a masterful address in which he touched upon many of the topics that are of current interest to all hospital administrators. His speech appears on page 49 of this issue of *THE MODERN HOSPITAL*.

There was a record attendance at the banquet held at the Chelsea Hotel on Wednesday evening. Doctor Burlingham ably presided while Dr. Frederic A. Washburn, director, Massachusetts General Hospital, Boston, acted as toastmaster and after the dinner and music first introduced the foreign delegates at the speakers' table. The next order of business was the presentation by John Olsen, formerly superintendent of Bushwick Hospital, Brooklyn, of the award for the best publicity display on National Hospital Day. Dr. Joseph R. Morrow, superintendent, Bergen County Hospital, Ridgewood, N. J., was the win-

ner of the much prized award while the following received honorable mention: California Lutheran Hospital, Los Angeles, Calif., Leonard Hospital, North Troy, N. Y., San Jose Hospital Council, San Jose, Calif., Good Samaritan Hospital, Portland, Ore., Mater Misericordia Hospital, Sacramento, Calif., United States Veterans Hospital, Sam Jackson Park, Ore., Jewish Hospital, St. Louis, Mo., King's Daughters Hospital, Greenville, Mass., Richmond Memorial Hospital, Princess Bay, N. Y.

Doctor Morrow made a speech of acceptance which was followed by three other speakers.

Doctor Washburn then introduced the speaker of the evening, Edwin R. Embree, president, Julius Rosenwald Fund, Chicago, who took as his topic, "Organized Medicine and the Patient of Moderate Means." Mr. Embree told of the progress that had been made in medical education from the time when the young man anxious to become a doctor first attached himself as an apprentice to an established doctor and worked his way up to the time when he could put out his own shingle and enter practice. Regarding hospitals he stated:

"The recent growth of hospitals and clinics is remarkable. During the past century, while the population of the United States has somewhat less than doubled, the number of hospitals has increased fifteen-fold. During the same period the number of hospital beds has grown from 35,000 to 860,000. Out-patient clinics have increased in much the same fashion in one-third the time. At the end of the past century the number of clinics in the United States did not exceed 100; to-day there are 6,000. The annual number of visits by patients to clinics has grown in these same thirty years from less than one-quarter of a million to more than six million.

#### *Hospital Organized First for Charity*

"The hospital was organized originally for charity. Even before we recognized the interdependence of the various groups of society, we expressed a charitable impulse toward the unfortunate. We established almshouses, relief stations and, in much the same spirit, charity hospitals. Our provisions to-day for the sick poor are so extensive and elaborate that if a pauper can show some acute illness he will be treated like a prince for a week or two in the wards of any one of our thousands of municipal or privately owned hospitals. Finding most of the best doctors and the best scientific equipment for diagnosis and treatment in these free hospitals, the rich patient began to demand service there, so hospitals began to add pavilions for private pa-

tients—where rich men can now get almost as good medical service as the poor."

Mr. Embree then outlined the many plans that are being made for the patient of moderate means and cited the Cornell Pay Clinic, New York, as an outstanding example of what can be done for these individuals.

Following the dinner dancing was enjoyed until a late hour:

#### *Officers-Elect Are Named*

The report of the nominating committee was heard on Wednesday afternoon when Dr. Lewis A. Sexton, director, Hartford Hospital, Hartford, Conn., was named for president; Dr. W. Colby Rucker, United States Marine Hospital, No. 14, New Orleans, La., first vice-president; Jessie J. Turnbull, superintendent, Elizabeth Steel Magee Hospital, Pittsburgh, second vice-president; Paul H. Fesler, superintendent, University of Minnesota Hospital, Minneapolis, third vice-president; Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, treasurer; Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Canada, trustee for three years, and Carolyn E. Davis, superintendent, Everett Hospital, Everett, Wash., trustee for three years. All of those named by the nominating committee were elected.

Resolutions on the death of Dr. Richard G. Brodrick, former president of the association, were introduced and passed. Doctor Brodrick's death was reported in *THE MODERN HOSPITAL* in the June issue.

Films showing the activities at Bergen Pines on National Hospital Day were shown.

Nearly all of the state associations held breakfasts, luncheons or dinners during the week. There was a meeting of the presidents and secretaries of state hospital associations. Many special groups held dinners and in fact from one end of the board walk to another were activities pertaining to some phase of hospital work. It would be utterly impossible to report the meeting in full because of its diversity and the many side lights that were continually being brought up but as detailed a summary as possible is given on the following pages.

Again let it be emphasized that this was the finest convention so far held and that credit for its success goes to the executive secretary whose untiring efforts did not ruffle his genial disposition at any time during the two strenuous weeks.

One of the features was the annual exhibitors party, held on Tuesday evening. The following new officers were elected for the coming year: president, L. C. Walker; vice-president, Stanley



*Edwin R. Embree.*

R. Clague; secretary, Frank L. Fischer; member of executive committee, Henry L. Kaufmann.

That between 200,000 and 250,000 persons were cared for in general hospitals in this country in 1928 as the result of highway accidents, is the estimate of Dr. Emil Frankel, director of research, New Jersey State Department of Institutions and Agencies, Trenton, whose address, "Hospital Problems Arising Out of the Care of Highway Accident Cases," opened the general session on Monday afternoon. Doctor Frankel based his estimate on automobile accident cases in New Jersey that required hospitalization last year.

The ability of the hospitals to collect their bills varied considerably. The total cost of hospital care in New Jersey was somewhere between \$600,000 and \$650,000, according to the estimate, and the financial loss to the hospitals was between \$250,000 and \$300,000. Using these figures as a gauge for the country as a whole the cost of hospital care for highway accidents amounted to between fifteen and sixteen million dollars, and the losses to the hospitals were between six and seven million dollars.

To what extent should the local community bear the financial burden arising out of the care of highway accidents that occur in the hospital's locality? Doctor Frankel asked. The financial problems arising out of the care of accident cases



*Dr. Frederic A. Washburn.*

are only partially a problem for the local community, he said. What then are the prospects for relief to the hospitals when accident cases refuse to pay their bills?

The adjustment of highway accident cases is just beginning to receive legal cognizance in a number of states. States including limited or partial compulsory automobile liability insurance features in their motor vehicle laws include Maine, New York, New Jersey, and Rhode Island. Massachusetts is the only state having general compulsory automobile liability insurance. However, the fact that a state has an automobile accident liability insurance law offers no guarantee to the general hospitals that they will be compensated automatically for services rendered in accident cases. Many states have attempted to meet the situation by giving the hospital the right of lien, according to Doctor Frankel.

Although compulsory automobile insurance laws offer no direct financial guarantees to the hospital, when the person who is responsible for the accident is insured, the hospital is much more likely to be reimbursed for the care given to hospital patients, he said. The general hospitals, then, may well interest themselves as to whether or not drivers of automobiles carry accident liability insurance.

Fifty administrators of general hospitals in

New Jersey when questioned concerning their experiences with highway accident cases gave answers that were summed up by Doctor Frankel as follows:

The majority of the hospitals gave an unusual amount of free service to highway and other non-industrial cases not properly belonging to the hospital district. It is difficult if not impossible to collect a large percentage of the bills. The insurance companies usually pay the injured person who in turn leaves the hospital without paying his bill. The hospitals feel, first, that the person responsible for the accident should assume the bill and, second, that some governmental authority should pay if the responsible person does not. Few hospitals place any responsibility on the patient who is being treated. Compulsory automobile insurance is recommended, with the liability insurance to be strictly under state control and each license to carry with it a liability policy. An organization similar to the Workmen's Compensation Bureau is suggested to adjust claims and to divide the available funds among claimants, including the injured person, the hospital, the doctor or others who have helped in the rehabilitation of the patient.

Dr. Arnold H. Kegel, commissioner of health, Chicago, followed Doctor Frankel and delivered an able address on "The Relationship of Hospitals to the Health Department of Large Cities." Doctor Kegel emphasized that there should be close coordination between hospitals and public health departments which have a common aim—to promote public health. Hospitals should be informed on all that the health departments are doing and should be prepared to take a larger civic responsibility. As an educational body they must train future physicians in the care of patients and in practical public health measures. They should keep records to show whether patients are residents of the city where the hospital is located so that the value of hospitals may be more readily measured. They should aid infant welfare societies and by training nurses they can promote public health.

#### *Health Departments Should Assist*

The health departments should give every possible assistance in carrying on nurse training by giving lectures on public health and can work with the hospitals in controlling communicable disease and general infections. They can aid by their activities in connection with general sanitation and ventilation and can control a nuisance-free zone around the hospital. In order that standards of safety may be maintained, architects and hospital planners should confer with

health departments in building new hospitals, Doctor Kegel said, so that a cooperative program may be worked out.

The medical director of Hudson County Tuberculosis Hospital and Sanatorium, Secaucus, N. J., Dr. B. S. Pollak, was the next speaker. He evaluated the work that has been done during the past twenty-five years in the treatment of tuberculosis and the control and prevention of the disease, and stated that the hospitalization of the tuberculous is the most outstanding agency in the control and final eradication of the disease. He feels that the greatest opportunity for benefit from therapeutic or institutional measures is during childhood and he stressed the importance of general living and working conditions. In New Jersey, he stated, the law demands that every county conduct a tuberculosis hospital. Tuberculous patients, Doctor Pollak holds, should be admitted to general hospitals, so that interns, students and nurses may be educated. He believes there should be tuberculosis clinics in all hospitals, so that young physicians may be equipped to diagnose tuberculosis.

Dr. Earl D. Bond, president of the American Psychiatric Association and superintendent, Pennsylvania Hospital for Mental and Nervous Diseases, Philadelphia, next presented a paper in which he described the institute for mental hygiene which has been established in Philadelphia. This institute will be run without a license, he said, as any surgical hospital is run. The visiting staff will be divided into two services, one for the University of Pennsylvania and one for Jefferson Medical College. The institute is intended to serve a group of patients who do not now come to hospitals, such as many convalescent patients, the fatigued, the worried, the overconscientious, the unduly prejudiced, those with an inferiority complex. Such patients are now pouring in. Here psychiatry will be applied to the needs of everyday life and the methods of the child guidance clinic will be applied to the adolescent and the adult. The institute represents an effort to make everyday life healthier and happier, Doctor Bond said.

A special feature of this session was an address on European hospitals by Dr. Julius Tandler, commissioner of health and welfare of Vienna, Austrian delegate to the International Hospital Congress. Doctor Tandler spoke in German and Dr. E. H. Lewinski Corwin, secretary general of the International Hospital Committee, acted as interpreter, giving a brief resumé of Doctor Tandler's address. An outline was given of how European hospitals arose, developing from very small and simple poorhouses. The



*Dr. E. H. Lewinski Corwin.*

evolution of hospitals, Doctor Tandler said, paralleled the development of social responsibility for the care of the sick and the development of medicine. Great progress followed the development of medical schools and specialization began. Hospitals in Europe have now become centers of modern social work. Doctor Tandler was emphatic in his description of the difficulties of hospital operation in Europe. He went into detail in relating the organization of the different departments of hospital service and outlined the function of each division of the hospital in an interesting manner. He also called special attention to the tuberculosis work being done in Vienna and told how it is carried on. At the conclusion of his address Doctor Tandler showed many lantern slides of Viennese institutions of different types, including hospitals for the mentally ill, homes for the aged, maternity hospitals and children's hospitals. The address of this illustrious scientist aroused great interest and was followed with close attention.

The reports of the following committees were next presented by the chairmen of the respective committees: clinical records, chairman, Dr. Christopher G. Parnall, medical director, Rochester General Hospital, Rochester, N. Y.; intern advisory, Dr. N. W. Faxon, Strong Memorial Hospital, Rochester, N. Y.; workmen's compensa-

tion, Richard P. Borden, Union Hospital, Fall River, Mass.; Smithsonian Institute, Richard P. Borden. The trustees' report was read by Dr. Bert W. Caldwell, executive secretary of the association. All of these reports were accepted on motions made from the floor. The report of the treasurer, Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, was not read but will be published in the "Transactions," as will the other reports.

Three round tables were scheduled for Tuesday morning, to run concurrently, under the chairmanship of Daniel D. Test, Pennsylvania Hospital, Philadelphia, Dr. W. L. Babcock, Grace Hospital, Detroit, and Robert Jolly, Baptist Hospital, Houston, Tex. It was suggested that Mr. Test's and Mr. Jolly's meetings be combined and this arrangement being found acceptable, the suggestion was carried out, and resulted in a lively discussion of many problems of current interest taken part in by delegates from all parts of the country under the inspiring leadership of Mr. Jolly.

Practical suggestions on how to safeguard the



Dr. N. W. Faxon.

hospital against the loss of radium and how to protect the persons handling radium were given by L. C. Austin, Mt. Sinai Hospital, Milwaukee. Radium is costly and if lost is hard to trace. Lay employees should therefore be enlightened regarding its value and cautioned against carelessness in handling it, Mr. Austin said. The order for radium should come from the physician or from his intern and should be in writing. This order should state how much radium is required, the length of time it is to be used and the condition for which it is to be used. When the radium is brought to the hospital a signed receipt for it should be issued by the department authorized to order it, usually the x-ray department. The lead box containing the radium capsules is then turned over to the intern or the physician. After the radium is inserted, the lead box radium container should be taken from the operating room by the operating surgeon's intern and delivered to the supervisor of the floor to which the patient has been moved. The lead box and alcohol for washing the capsules should be available to the intern or physician at the time the radium is removed. The intern or physician who removes the radium should deliver the cleaned capsule in the lead box to the x-ray department, when the proper receipt will again be given. This routine makes the fewest possible number of individuals responsible for the radium while it is in the hospital, Mr. Austin said.

#### *Many Problems Discussed*

Other questions that came up for discussion at this session were: What is ethical publicity for a hospital? What is the best way to handle meal charges against special nurses? How should laboratory charges be made? Ought a hospital to give free service to employees? How shall we pay our x-ray director? Ought a hospital to give a monthly allowance to student nurses? Among those who took a prominent part in suggesting solutions for some of these vexing problems were the following: J. H. Trayner, Idaho Falls Hospital, Idaho Falls, Idaho; Dr. R. W. Plummer, Graduate Hospital of the University of Pennsylvania; Dr. Louis Levy, Jewish Hospital, Cincinnati; Dr. John F. Bresnahan, St. Mark's Hospital, New York; J. O. Sexson, Good Samaritan Hospital, Phoenix, Ariz.; Mrs. Alice Taylor, All Saints Hospital, Fort Worth, Texas; Mrs. Valentine R. Bosworth, Chicago Memorial Hospital, Chicago; Carolyn E. Davis, General Hospital, Everett, Wash.; Richard P. Borden, Union Hospital, Fall River, Mass.; Jessie J. Turnbull, Elizabeth Steel Magee Hospital, Pittsburgh; Gertrude E. Copeland, Independence Sanitarium,

Independence, Mo.; Robert E. Neff, University of Iowa Hospital, Iowa City, Iowa.

An interesting feature of this round table was a talk on "Insurance Costs—What Makes Them?" by E. M. Sellers, Indiana Inspection Bureau, Indianapolis. Mr. Sellers explained the need for modern fireproof construction in hospitals, with adequate protection facilities and sufficient and accessible exits, with a view to safeguarding life and property. He stated that approximately 75 per cent of hospitals are of brick and wood joisted construction, making them potential furnaces. He next explained that inspection and rating bureaus are maintained by the stock fire insurance companies and outlined what the Indiana Inspection Bureau is doing and what it has accomplished. The work is in charge of a man who has made a study of this matter, he said. This engineer visits and inspects hospitals and frequently the hospital superintendent accompanies him on his annual inspection of the hospital. The matters to which he gives his attention are the proper storage of x-ray films; housekeeping conditions that have a bearing on the fire hazard; laboratories and drug rooms; operating room hazards, such as anesthetic gases. He also examines the hospital's insurance policy. He then prepares a report giving an account of the conditions found and offering recommendations for the improvement of the hospital in relation to its fire hazards. Such service is available in all states, Mr. Sellers said, at no expense to the hospital.

At the conclusion of the round table Mr. Jolly was given a rousing vote of thanks for the admirable way in which he had conducted the discussion and his success in interesting those present and inducing them to take part in the questions and answers.

#### *Important Points Heard at Round Table*

The first subject to be discussed at the round table conducted by Dr. Warren L. Babcock, director, Grace Hospital, Detroit, was "The Patient of Moderate Means," by Dr. Frederic A. Washburn, director, Massachusetts General Hospital, Boston. Doctor Washburn told of what was being done at his institution which at the present time is leading the other hospitals of the country in actually doing something for the much discussed middle class. The new buildings, the agreement with the medical profession and other features of the plan were told.

Dr. N. W. Faxon, director, Strong Memorial Hospital, Rochester, N. Y., discussed the rules regulating the intern staff and stated that if intern service was proving valuable in lessening the



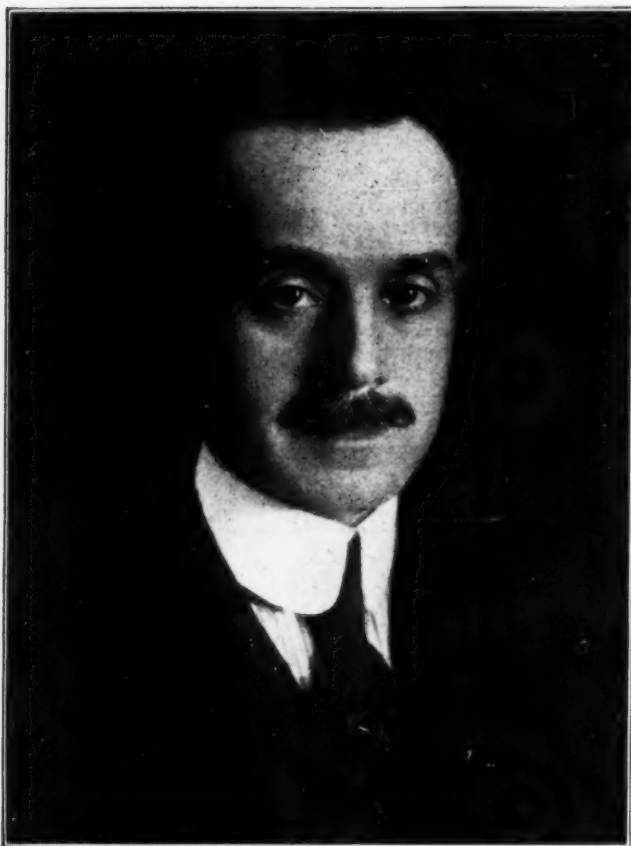
*Richard P. Borden.*

number of days' stay for patients in the wards he was of the opinion that it would also be of great value in the private rooms. He outlined the rules that were in effect at Strong Memorial Hospital and urged those present to give more attention to the intern problem, so that all of the patients would be benefited to a greater extent.

Elmer E. Matthews, superintendent, Wilkes Barre General Hospital, Wilkes Barre, Pa., told of the work of the credit investigator in hospitals. Mr. Matthews emphasized the need of careful investigation of all cases where either free work or part-pay work was considered, and cited several instances when precaution had resulted in added income to the hospital.

Because of the recent Cleveland Clinic disaster much interest was attached to the remarks of H. E. Newell, Fire Underwriters' Association, New York, when he outlined the various fire hazards to be found in hospitals. He emphasized the common hazards such as the storage of x-ray films, faulty wiring, poor housekeeping, improper exits, infraction of rules by the hospital personnel, and told how each of these could be eliminated to the end that the patient would be safer and the insurance premium less.

Clarence H. Baum, superintendent, Lake View Hospital, Danville, Ill., reviewed the purchasing of supplies and the storage of supplies in hospitals. Mr. Baum made clear the point that the superintendent should be responsible for the purchasing of all those things that are in daily use



Dr. George O'Hanlon.

in the institution and that he should keep abreast of the times so that he is familiar with the current prices and the reasons for the prices quoted by the manufacturers.

Sidney G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., closed the session with a paper on "The Study of Uncollectible Accounts of Accident Cases." Mr. Davidson has recently completed a study of auto accident cases in Michigan in which he discovered that a large percentage of free work in hospitals was caused by the admission of this type of emergency work for which the hospital was unable to collect. He urged concerted action on the part of all hospitals in checking what is becoming a growing evil in hospitals.

One of the important events of Tuesday afternoon was the meeting of the teaching hospital section, under the chairmanship of Paul H. Fesler, University of Minnesota Hospital, Minneapolis, Minn. At the San Francisco meeting last year the teaching section was devoted to discussion of ways and means of establishing standards for teaching hospitals. As a sequel to this, Mr. Fesler planned this year's program to bring out discussion as how best to standardize the professional departments of the teaching hospital. There was a splendid attendance at the meeting of those

whose interests center around the teaching hospital and its problems.

The first speaker was Anna Boller, president of the American Dietetic Association, Chicago, whose subject was "The Dietary Department of the Teaching Hospital."

Because the hospital is the most satisfactory place to train persons who are to help those who are ill back to health, it is the ideal place for the training of medical social workers, according to Grace Beals Ferguson, George Warren Brown Department of Social Work, Washington University, St. Louis, whose paper, "The Teaching Hospital's Part in the Training of Medical Social Workers," followed that given by Miss Boller.

#### *Hospital Offers Valuable Training*

While the social worker has had her basic training elsewhere, it is in the hospital that she learns the specialty of medical social work, Miss Ferguson pointed out. That the teaching hospital does play an important part in such training has been shown by the action of the American Association of Hospital Social Workers in designating certain hospitals as especially equipped to give field practice, to provide formal instruction in the medical course for social workers and to present the opportunity for the students to participate in medical social research.

Since one of the surest ways in which skill can be developed is through practice, the teaching hospital provides the medical social worker with a place for practice, the "field work" that is so necessary to her training, Miss Ferguson said. In her field work experience the student actually carries on those activities that make up the job of the trained worker. In some hospitals special ward rounds may be conducted for the social workers, and the physician directing them particularly stresses the correlation between the social aspects of the case and the medical problems.

The social worker in the hospital must have medical knowledge of a very definite sort and the teaching hospital is the logical source of this knowledge, Miss Ferguson believes. The basic course in medicine must be general, presenting the etiology, symptoms, diagnosis, treatment and prevention of the most common diseases.

If in addition to her skill and knowledge the embryo medical social worker can participate in or observe the research function of the hospital, then her skill and knowledge are given depth, Miss Ferguson declared. Assisting the physician in a research project aids in training the student to be accurately analytical and honest in drawing conclusions.

That gratifying development in hospitals under

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university control for clinical teaching and in large public hospitals, under governmental or private control, for supplemental teaching of undergraduates and for the training of interns and residents has come about in recent years, was pointed out by Dr. C. R. Bardeen, dean, University of Wisconsin Medical School, Madison, whose paper, "Teaching Hospitals," was heard with a great deal of interest.

In Doctor Bardeen's absence, Dr. R. C. Buerki, University Hospital, Madison, Wis., outlined the main points of the paper and mimeographed copies of Doctor Bardeen's statistics were distributed to those present.

The most widely extended form of organized professional teaching in hospitals is that of training courses for nurses, according to Doctor Bardeen who said that 2,286 out of 7,269 or nearly a third of all the hospitals in this country offer such courses. The next most widely extended use of hospitals for professional training is that of interns. Of the 4,322 general hospitals on the list of the American Medical Association, 609 were approved for intern training in 1928. The American College of Surgeons approved 1,577 hospitals last year, 23 per cent of the 6,807 hospitals recognized for registration by the American Medical Association.

Hospitals that offer suitable advanced practical training in medicine may be divided into three groups—those that are approved for both residencies and internships, those that are approved for internships but not for residencies in the specialties and those that are approved for residencies in the specialties.

#### *Preceptor System Approved*

From the standpoint of undergraduate medical instruction hospitals may be divided into two main groups—school hospitals and other undergraduate teaching hospitals. School hospitals are of three types, university, college and intermediate. Other undergraduate teaching hospitals are of two kinds, staff appointment and permissive. Staff appointment hospitals are those in which one or more medical schools are granted the right to appoint the medical staff or one or more services utilized for undergraduate teaching. Permissive hospitals are those in which no definite rights concerning staff appointments have been assigned to medical schools but in which the privilege of teaching has been extended either directly to the medical school or indirectly through members of the hospital staff who have appointments on the faculty of the medical school.

Concerning the method of teaching, Doctor Bardeen believes that there is much of value in



*Dr. Malcolm T. MacEachern.*

the old preceptor system and that there would be much to be gained by introducing it under modern conditions of hospital service.

The next speaker was Mary E. Gladwin, director of education, St. Mary's Hospital, Rochester, Minn., whose subject was "What the Teaching Hospital Can Do in Solving the Nursing Problem." In the last ten years university schools have increased greatly, Miss Gladwin said, and this increase is welcome but it calls for a standard curriculum. Such schools should plan a program of practical work and do away with theory, they should give leadership in nursing education, they should contribute to the research work in their field. The chairs of nursing education at Columbia University, at Yale University and at Western Reserve University, Cleveland, have, Miss Gladwin feels, had enormous influence in arousing interest in the subject of nursing and have added prestige to the profession.

Dr. N. P. Colwell, secretary, Council on Medical Education and Hospitals, American Medical Association, Chicago, next opened the discussion on teaching hospitals, giving a description of the teaching hospitals of the United States, and outlining the history of the development of medical schools in this country. He spoke of the rapidity with which they grew and the later need for reducing their number by mergers. He also gave



*Bertha E. Beecher, chairman, dietetic section.*

statistics on the number of hospitals in the United States and emphasized their importance in an educational way.

International speakers next explained the teaching hospitals of Europe, those taking part and the countries they represented being as follows: René Sand, France; Dr. W. H. Mansholt, Holland; Prof. E. S. H. Key, Sweden; Prof. Julius Tandler, Austria; Dr. J. Sebrechts, Belgium; Prof. Aladar Von Soos, Hungary; Dr. A. E. Henry, Egypt. Dr. René Sand acted as interpreter for these speakers, whose remarks on hospitalization as it is practiced in foreign countries aroused marked interest among those present.

Dr. Michael M. Davis, Julius Rosenwald Fund, Chicago, presided at the meeting of the out-patient section and Dr. Morris Fishbein, editor, *Journal of the American Medical Association*, Chicago, was the first speaker, taking the place that had been assigned to Dr. Malcolm L. Harris, president-elect of the American Medical Association. Doctor Fishbein gave the attitude of the association on the establishment of clinics either in connection with hospitals or independently. He alluded to several clinics in Chicago that have been frowned upon by members of the medical society and told the type clinic that was acceptable to the medical association.

Edward A. Filene, president, William Filene

and Sons, Boston, discussed the subject from the viewpoint of the public. He discussed the subject of cost of medical care and urged that the association do something to reduce this cost to the general public.

Dr. Julius Tandler, commissioner of health and welfare of Vienna, told of the work that the clinics of Europe are doing and the advancements that are being made in this work where all of the poor are accepted as being charges of the state. The clinics of Europe differ from those in America in many respects, according to Doctor Tandler.

Doctor Davis closed the session by the presentation of the report of the out-patient committee, which dealt primarily with diagnostic clinics rather than treatment clinics.

Dr. Donald C. Smelzer, superintendent, Charles T. Miller Hospital, and director Amherst H. Wilder Dispensary, St. Paul, Minn., who has been secretary of the section for the past two years was elected chairman.

The largest single session of the meeting was held on the stage of the auditorium on Tuesday afternoon when Dr. C. W. Munger, director of Grasslands Hospital, Valhalla, N. Y., conducted the administrative session. There were present more than 500 people and many of the subjects presented brought forth lively discussion. Clarence H. Baum, superintendent, Lakeview Hospital, Danville, Ill., acted as secretary of the meeting.

The first paper read was by Dr. Carl E. McCombs, Bureau of Municipal Research, New York City.

The need of a well equipped, well managed bureau of research for the hospital field was emphasized by Dr. Carl E. McCombs, Bureau of Municipal Research, National Institute of Public Administration, New York City, the first speaker on the administration section program.

#### *Factors of Organization Outlined*

In outlining the principal factors he believes necessary in the organization of such a department, Doctor McCombs declared that the bureau should be nonprofit-making; that it should be equipped to provide hospital authorities with the latest possible information on matters of immediate concern; that it should be affiliated with a university in order that the results of its work may be incorporated in courses of instruction, and that it should be permanent in character, financed, if possible, through endowment.

Doctor McCombs also listed some of the most important duties of a bureau of research, describing, by way of example, some of the results attained by the organization with which he is

identified. The detailed program of such a bureau, however, can be determined only after it has been organized and after research opportunities and needs are balanced against financial resources, he said.

Some of the outstanding problems to be considered by a research department would include the following, according to Doctor McCombs' suggestions:

*Problems for Research Listed*

Hospital requirements for communities of various sizes and of varying character and composition of population; the development of indexes of hospital efficiency that will permit the appraisal of hospitals on somewhat the same basis now used for appraising public health services; the various types of administrative organization of hospitals and the adaptation of these types to hospitals of varying sizes and varying relationships to other health and welfare services of government; standardization of salaries of hospital workers; hospital cost accounting; hospital nursing and its relation to nursing education; training of hospital interns; relations of government to hospital services generally; advantages or disadvantages of hospital maternity care as compared with home maternity care; relations of the hospital medical staff to hospital management; training of hospital executives, and hospital fire protection.

Col. R. E. Longan, superintendent, Baltimore City Hospital discussed the paper and told how research work had been successfully carried on in Baltimore. He was followed by Dr. Walter Goodale, superintendent, Buffalo City Hospital, Buffalo, N. Y., who disagreed and based his disagreement upon his own experience in Buffalo where for some time a dispute has been going on regarding Doctor Goodale's hospital. Dr. Emil Frankel, director of research, New Jersey State Department of Institutions and Agencies, Trenton, N. J., upheld Doctor McCombs, as did other speakers on the program. The outcome of the dispute was that on a motion by Sidney G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., the matter was referred to the board of trustees of the American Hospital Association.

An excellently presented paper was then given by Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore. Doctor Smith told of the work that is being done by the Committee on the Cost of Medical Care and explained several of the things the committee expects to do in presenting to the public an unbiased report on just wherein the cost of medical care lies. He cautioned those present not to jump at conclusions or to expect a panacea in the reports as they will appear and



*Carrie M. Hall, chairman, nursing section.*

further emphasized the fact that the committee was often misnamed the committee on the high cost of medical care, whereas the proper name was the Committee on the Cost of Medical Care.

Doctor Smith's paper was followed by a discussion of it by Dr. Donald Morrill, superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich. and Dr. Malcolm T. MacEachern associate director, American College of Surgeons.

The next paper was entitled "What the Foundations Have Done for American Hospitals." by John A. McNamara, executive editor, THE MODERN HOSPITAL, Chicago.

The advantage of the foundation, said Mr. McNamara, is that it eliminates waste in giving, those in charge usually making a careful study to determine who shall receive help. Mr. McNamara described the work of a number of well known foundations or endowment funds and said that there was practically no duplication among the work of these various foundations. The medical research that has been carried on by the Rockefeller Foundation has been of great value to hospitals, he said.

The social activity of the Rockefeller Foundation in the backward parts of the South, according to Mr. McNamara, has been supplemented by three other foundations, the Duke Endowment, the Rosenwald Fund and the Commonwealth



Paul H. Fesler.

Fund. Thirty-two per cent of the income of the Duke Endowment—between \$500,000 and \$600,000—goes for hospital work in the Carolinas.

Mr. McNamara's paper was discussed by Dr. W. S. Rankin, director, hospital section, Duke Endowment, Charlotte, N. C. Doctor Rankin stated that since the first figures had been published the amount of the endowment had increased until now it was nearly \$75,000,000 instead of \$40,000,000. He stated that one of the features of the work that was being done was the help that it was bringing to better public health and medical care in the smaller communities of the South.

#### *The Hospital in Relation to Public Health*

The closing paper of the meeting was given by Dr. Matthias Nicoll, Jr., New York State Commissioner of Health, Albany, who spoke on "The Place of the Hospital in the Promotion of Public Health Programs."

That one of the most important factors in the progress of modern public health is readily available through efficient hospital service, both general and special, is the opinion held by Dr. Matthias Nicoll, Jr., commissioner of health, New York State, who was the fifth speaker on the administration section program.

Doctor Nicoll emphasized particularly the place

that special hospitals can have in a preventive health program, saying that a tuberculosis sanatorium should be the center of antituberculosis work, especially throughout rural districts, that the problem of the care of the insane and mentally defective can be solved only by adequate appropriation for the construction and scientific functioning of special institutions and hospitals, that suitable hospital provision should be available for the early diagnosis and treatment of cancer, that there should be more hospitals to which cripples may be sent for rehabilitation and that, because of the high mortality among pregnant women, there should be more facilities for the hospitalization of maternity cases.

#### *Rural Districts Want Own Doctors*

Despite the fact that good roads and automobiles assure as good medical service to rural communities as was formerly rendered by strictly local physicians, there can be no doubt but that it is the innate desire of most isolated communities to have their own medical advisors, he said. Among the factors necessary to keep good physicians in rural districts are adequate hospital facilities, a fact that accounts for the constant increase in the number of community hospitals that is now taking place.

The function of the community hospitals, according to Doctor Nicoll, is to provide up-to-date medical care and surgical treatment and to improve the practice of medicine by furnishing consultation service and advice to the general practitioner. The community hospital must stand ready to provide medical service not only in the hospital but in the home, to every person requiring such care. Doctor Nicoll then described a successful community hospital that is serving a strictly rural county of 35,000 persons and parts of adjoining counties, with a total population of 50,000. It is equipped with every modern appliance and provides the highest type of surgical and medical, laboratory and x-ray service. This community is practically independent of outside medical and surgical aid.

Such community hospitals would not be "health centers" in the very beginning, he said, but there would be no doubt but that they would serve as centers for state and local health activities such as public health nursing, prevention of diphtheria, prenatal care, child welfare and, in the absence of a local tuberculosis hospital, tuberculosis clinics. They may well be the meeting place also for conferences between health officials, state and local, and the general medical profession.

Doctor Nicoll paid tribute to Dr. C. W. Munger for the hospital work that is being carried on in

Westchester County, N. Y., under his guidance.

The paper was ably discussed by William J. Ellis, Commissioner of Institutions and Agencies of New Jersey, Doctor Goodale and Dr. R. C. Buerki, director, University of Wisconsin Hospital, Madison, Wis.

A report of the committee on public hospitals was given by Dr. C. W. Munger, and a report of the standardization committee was given by Margaret Rogers, superintendent, St. Luke's Hospital, St. Paul, Minn.

Doctor Goodale was nominated and elected chairman of the administrative section for next year.

The Tuesday evening joint meeting of the National League of Nursing Education and the American Hospital Association was held in the ballroom of the convention hall, when a crowded attendance demonstrated the interest attendant upon the solution of problems that are common to the nursing and the hospital fields. The spirit of cooperation that has characterized these two national bodies in their efforts to elucidate the difficulties affecting their members and define a correct line of procedure was further emphasized in this joint meeting, presided over by Dr. L. H. Burlingham, president of the American Hospital Association and Elizabeth C. Burgess, R.N., president of the National League of Nursing Education. On this occasion eminent and informed speakers took part in the program and demonstrated by careful analyses different aspects of the complicated situation that confronts the nursing profession and adversely affects the members of both bodies, whose interests are closely allied.

#### *Schools of Nursing Are Discussed*

The first speaker for the League was Carrie M. Hall, principal, school of nursing, Peter Bent Brigham Hospital, Boston, her subject being "Nursing Education From the Viewpoint of the Principal of the School of Nursing." Miss Hall was president of the League from 1925 to 1928 and is now a member of its board of directors. She has been in charge of a school of nursing for years and has come in contact with the practical problems that beset a principal of a school who is also a director of nursing in her hospital. She knows how often education must be sacrificed to patients' welfare when hospital nursing service is dependent upon student nurses only. Her talk was practical but was inspired by ideals for improving the care of the patient and enriching the education of the nurse.

The dual position of principal of a school and superintendent of nurses is a difficult one, she said, for students in order to get the most from



*Dr. Michael M. Davis.*

their nursing course must be closely supervised. There is great need for improving the quality of nursing service, Miss Hall feels, and she believes that nursing education has progressed as far as it can under hospital control and that if the apprenticeship training is unsatisfactory we should abandon it, and replace student nurses with graduates. The place to teach nursing is in the hospital but good nursing can be taught only where good nursing is being practiced and with student nurses it is impossible to guarantee the quality of nursing, she said. In conclusion Miss Hall stated that she believes the public more or less resents student nurses.

"Nursing Education From the Viewpoint of the Hospital Trustee" was the next subject considered and this was interestingly handled by Richard P. Borden, president, board of trustees, Union Hospital, Fall River, Mass.

"The trustee of a school of nursing has a very definite aim," Mr. Borden declared. "It is to provide good facilities for nursing. Poor nurses, poorly educated, would be a menace rather than a benefit."

Mr. Borden declared that trustees generally believe that their obligation is to educate women for the general duties of a nurse, not for the duties of instructors, supervisors or other special purposes.

"The specialties require special means of education," he declared. "And all that the average school of nursing should be expected to do is to provide adequate general nursing education for one capable of making proper use of it for the public good as well as her own.

"It is believed that the average school will be compelled by natural causes to perform this duty acceptably.

"It is a fact, nevertheless, that irresponsible and ignorant persons do enter the field of alleged nursing education. Every year, like the blade of grass, a new hospital grows where one never grew before, and its trustees undertake an entirely novel task, hard to perform because of inexperience, however good the intention. Some standard for their guidance will keep them out of many pitfalls, dangerous to the patient and injurious to the nurse, to say nothing of the hospital and school which the trustees are trying their best to serve. Standards should not be set up except to lead in the right direction, and they should be carefully considered and devised for that purpose.

"Who is to determine what the standard shall be? Is it not true that the parties primarily

interested and therefore qualified to judge are physicians and hospitals under whose direction nurses must perform their duties? The physician wants a nurse qualified to do what he requires of her; the hospital wants nurses to do nursing work in the hospital. The business man, transformed for the time being into a hospital trustee, would spend no money in educating a nurse in subjects which do not yield a proper return on the investment. They must be taught subjects of practical value in the work to be performed, and this imperative law has been at work ever since the task of educating women to be nurses was begun. It is this law that has brought about changes in methods of education. The law is still in force, and standards of education on which the grading of schools is to be founded must conform to it. In the last analysis, the trustee submits, hospitals will determine the standards by continuing to maintain schools which will fill the nursing need of their institutions."

While schools of nursing have reached a high standard of educational attainment, many still have not conformed to the standards accepted in other education fields, according to Dr. B. W. Black, medical director, Highland Hospital, Oakland, Calif., whose paper on "Nursing Education From the Viewpoint of a Hospital Administrator," was read by A. L. Slack, Samuel Merritt Hospital, Oakland. According to Doctor Black, too many schools are graduating nurses on the basis of time served rather than on the basis of professional attainment. Poorly trained graduate nurses are the result.

#### *Adequate Care of the Sick Should Be Chief Aim*

The hospital administrator can have no other ideal than the adequate care of the sick and he must realize that in the school of nursing he is maintaining an educational institution in which the highest educational achievements are to be met, he pointed out. In the school a distinctive effort must be directed toward the development of morale, professional enthusiasm and an idealism and ethical standard that will make the nurse distinctive in her profession when she is graduated. To meet the highest ideal the school for nursing must approximate the standards represented by the better colleges. The aim should be quality rather than quantity. Doctor Black took to task the graduate nurse who is unwilling to do bedside nursing, pointing out that many superintendents of nurses prefer to use student nurses in this kind of work.

A school of nursing will cost money, he emphasized. It is the experience of many hospital ad-



Mrs. Fred Merrick and Dr. John D. Spelman.

ministrators that it is more economical to employ graduate nurses and eliminate the student nurse with the attendant expensive training school. There must be then a tangible reason why the future will require that certain hospitals continue to operate schools of nursing. Such schools should have a separate budget, and only hospitals that are able and willing adequately to finance the school to meet the new educational standards should remain in the educational field.

#### *Nursing Problems Similar to Those in Business*

The last speaker of the evening was Colonel Leonard P. Ayres, vice-president, Cleveland Trust Company, Cleveland. His paper was entitled "Our Problems." Colonel Ayres is an educator as well as a financier. He believes that fundamentally many of the problems that disturb the nursing profession are similar to those of a business firm trying to improve its personnel in order to enlarge its business. He discussed the nursing question from the educational viewpoint and from the business viewpoint and illustrated his points by reference to the educational and banking worlds, showing how certain aspects of nursing appear to a business man and what the profession might learn from business and education.

Colonel Ayres predicted that the great development in nursing education would come not through separate schools of nursing but through schools controlled by hospital boards. It seems to be accepted, he said, that the superintendent of the hospital under present conditions has little direct responsibility for the school of nursing, a situation which seems to be fundamentally unsound. If the school of nursing is to develop along satisfactory lines, the person responsible for it must be the chief executive officer of the hospital, who is the superintendent. It therefore seems a logical conclusion, Colonel Ayres said, that those persons who are most definitely interested in nursing education, which probably means the superintendents of nursing, should seriously consider studying to fit themselves to become superintendents of hospitals so that the control of the schools might be directly under the officers who have direct access to the boards of trustees and who are also experts in nursing education.

This evening's program was emphatically profitable from every standpoint and those who attended left the hall refreshed and stimulated toward future efforts to develop an educational program for the many thousands of young women who are entering the nursing field.

The meetings on Wednesday morning again took round table form, special problems of hos-



*H. Eldridge Hannaford, Fred Merrick and Mrs. Hannaford.*

pitals being discussed under the joint chairmanship of Dr. N. W. Faxon, Strong Memorial Hospital, Rochester, N. Y., and Dr. John F. Bresnahan, St. Mark's Hospital, New York City, and outpatient work under the chairmanship of Michael M. Davis, Julius Rosenwald Fund, Chicago.

Doctor Davis' round table was led off by a paper on "The Responsibility of the Hospital Social Worker in Determining Fees" by Elizabeth P. Rice, Boston Dispensary, Boston. Because the hospital social worker has access to an intimate knowledge of the economic and social status of a prospective patient, she is the logical person to determine his eligibility for treatment in outpatient departments, declared Miss Rice.

"We shall agree, probably, that there should be restriction of patients to public clinics according to their economic condition," Miss Rice stated. "And since patients are to be restricted who in the hospital is best equipped to determine which patients should be admitted and at what rates? This is dependent upon the manner in which the restriction is made, but if the patient is considered as an individual in all his outside relationships, his family, work and racial background, the social worker seems best adapted to determine his eligibility. She is trained in a social case work approach, part of which means that she can extract from the patient the relevant data without antagonizing him or seeming to be curious. If the

patient resents her questioning, she understands a proper psychological method of controlling his resentment and making him calm. She knows how to explain to him, in terms he can understand, the reasons why the hospital must have this information. "This can usually be done in terms of welfare to the patient rather than in terms of protection to the hospital and its physicians. One, the patient readily sees; the other is too institutional for him to grasp. The approach, therefore, to obtain such data is a social case work approach and hence one in which the social worker should be more skilled than a nurse or clerk."

Miss Rice's paper aroused considerable discussion, taken part in by Dr. Joseph B. Howland, Peter Bent Brigham Hospital, Boston, Dr. R. W. Plummer, University of Pennsylvania Hospital, Philadelphia, Alice M. Cheney, Peter Bent Brigham Hospital, Boston, Joseph J. Weber, Vassar Brothers' Hospital, Poughkeepsie, N. Y., Paul Fesler, University of Minnesota Hospital, Minneapolis, Minn., Frank E. Wing, Boston Dispensary, Boston. The majority of the discussions rather clearly favored the use of the trained medical social worker in the admission of out-patients, although some felt that a less highly trained person could fulfill this function.

Other questions considered at this time were: How can we best secure the attendance of the older physicians in the out-patient department? What are the best methods of coordinating records between the hospital and the out-patient department? Sidney G. Davidson, Butterworth

Hospital, Grand Rapids, Mich., Dr. James W. Manary, Boston City Hospital, Boston, Dr. Henry C. Wright, Bellevue Hospital, New York City, Doctor Davis and Doctor Plummer contributed to the discussion of these topics.

Election of officers for the section took place at the conclusion of the round table, resulting in the election of Dr. Donald C. Smelzer, Charles T. Miller Hospital, St. Paul, Minn., as chairman and Dr. Charles C. Hedges, assistant director, Johns Hopkins Hospital, Baltimore, as secretary.

On Wednesday afternoon the construction section was conducted by Dr. George O'Hanlon, Jersey City Hospital, Jersey City, N. J. There was a splendid attendance at this meeting. James R. Mays, Homeopathic Hospital, Providence, R. I., opened the program by giving a detailed description of the new nurses' home at his institution. This home accommodates 105 nurses, each of whom has a separate room. The classrooms are in the home rather than in the hospital. The average cost per bed was \$2,909, Mr. Mays stated.

The report of the committee on hospital construction, presented by Dr. S. S. Goldwater, consultant, New York City, chairman, concerned itself primarily with a list of topics intended to remind the architect of questions calling for consideration in the planning of a program for a hospital ward.

It discussed the requisites of a satisfactory ward plan, pointing out that the ward should be planned to facilitate nursing and medical care of the ward patients. In preparing the report the committee had in mind general ward planning,



*The newly elected officers of the Hospital Exhibitors' Association are shown here. From left to right they are: Henry L. Kaufmann, member of executive committee; Stanley R. Clague, vice-president; J. E. Hall, executive committee; L. C. Walker, president and Frank L. Fischer, secretary.*

*Dr. John Copeland, Mrs. Donald Smelzer, James McNee and Doctor Smelzer were photographed as they appeared on the board walk between meetings.*



but it was pointed out that the problems the architect faces in planning for the care of ordinary medical or surgical cases are to a large extent similar to those that are encountered in the planning of wards for special clinical departments and thus the report should be valuable regardless of the kind of hospital he is considering.

The report made many suggestions that were not intended for general adoption. The report restated also certain details of construction and equipment that had been listed in a previous report on private hospitals.

The "panorismic" plan of hospital construction was described and illustrated in detail by F. T. H. Bacon, consulting building engineer, New York City, who spoke after Doctor Goldwater had made the committee report.

The fundamental principle of the plan as presented by Mr. Bacon is the visual control of all patients, nurses and others in a unit from one point, together with the essential that this control must be possible with wards or rooms of from one to not more than four beds. The plan, he said, will cost more per cubic foot to construct than a conventional design, due principally to the greater perimeter of the outside walls and the cost of auxiliary utilities. The operating costs of such a building, however, will be lower than those of a conventionally planned structure. The interest and other fixed charges caused by the increase in capital cost will be more than offset by this lower operating cost. The greater convenience of the proposed plan for the nursing and medical staff and the patient is difficult to translate into dollars and cents but should be credited against the capital cost of the building.

An analysis of seven modern hospitals, accord-

ing to Mr. Bacon, gives 7,309 as the average number of cubic feet of construction per patient. Figures for six hospitals with the same basic conditions, laid out according to the "panorismic" plan give 5,201 as the average number of cubic feet of construction per patient.

The public pavilions of twenty-eight beds each are to occupy the lower floors. Above these, with a slight setback for architectural and practical reasons, the semiprivate pavilion of nineteen beds is developed. It is proposed to build the private pavilions above the semiprivate pavilions, and the design works out to fourteen rooms in each pavilion, a majority with bathrooms and all toilet facilities.

The administrative part of the hospital, the operating rooms, laboratories and other necessary auxiliaries can be easily planned, Mr. Bacon said, adding that complete plans have been made for hospitals which range in size from 200 to 700 beds.

Arthur A. Fleisher, president, board of trustees, Jewish Hospital, Philadelphia, presided at the meeting of the trustees' section which was also held on Wednesday afternoon. He introduced as the first speaker Philip C. Staib, president, Bergen County Hospital, Ridgewood, N. J., who spoke on trusteeship. Mr. Staib stated that his conception of the duties of a trustee was one of management working with the superintendent of the hospital. He urged closer cooperation with the hospital superintendent and asked those present to apply real business principles to the work in the hospital.

Following Mr. Staib on the program, Ethel Kincaid Greenbaum told of the aims of the Civic Hospital Association of Chicago and described the

efforts that are being made to place proper hospital service within the reach of all persons.

The association, she said, has the cooperation of the leading hospitals of Chicago. It is not incorporated for profit and is sponsored by a board of public spirited men and women. The control of the association is under the direction of a board of directors and a hospital board composed of superintendents of the cooperating hospitals. The chairman of the hospital board is a member of the board of directors.

There are two classes of membership, Mrs. Greenbaum went on to say, the cost to the member in each class being less than five cents a day. Class A membership costs \$18 a year and entitles the member to hospital service for not more than fourteen days a year, the service to consist of private room, board, floor nurse, ordinary medicines, use of operating room, use of delivery room and routine laboratory examinations. Class B membership costs \$14 a year, the service differing only in the fact that the patient occupies a semiprivate room.

Samuel S. Schwab, editor of the *Public Ledger*, Philadelphia, followed Mrs. Greenbaum's talk with a paper on "Publicity and the Best Type of Publicity for Hospitals and Kindred Institutions."

Mr. Schwab's address, the last on the trustees' section program, emphasized the willingness of all good newspapers to cooperate with hospitals in their publicity programs.

#### *Newspapers Willing to Aid Hospitals*

Mr. Schwab began by saying that "the very soul of a newspaper is public service," and that it is up to the hospital to bear this in mind when seeking newspaper publicity. Every great newspaper, he said, takes a civic pride in aiding and cooperating with those who are building and expanding the city's municipal institutions whether they are supported by the state or by endowments. A great deal more could be accomplished both by and for the hospital if there were clearer understandings between those in charge of the various campaigns for the hospital and the newspapers.

A good newspaper, Mr. Schwab asserted, cannot and will not open its columns to propaganda. But it will print legitimate news and that only. The hospital wants publicity and the newspaper wants news, he said. The problem then that confronts the hospital is to give to its publicity "that vital spark that arouses reader interest." It must get away from the special group idea and present the publicity in a way to make it deserve space in the newspaper.

Mr. Schwab spoke of the need for reciprocal

aid from the hospital and pleaded for a sympathetic attitude on the part of the hospital toward the reporter. All hospital employees should be instructed, he said, to cultivate a friendly feeling for the reporter and to deal with him frankly and courteously when he asks for information. Newspapers cannot tolerate an indifferent attitude toward the reporter since he stands as high in his field as the doctor and the hospital superintendent stand in theirs.

All of the papers presented were ably discussed and the attendance at this meeting was much better than in former years.

#### *Many Nursing Suggestions Presented*

On Thursday morning Muriel E. Anscombe, Jewish Hospital, St. Louis, conducted a round table on nursing. Several excellent papers were presented at this time and Miss Anscombe skillfully drew forth comments and suggestions so that the discussion was participated in by a great many of those present.

The opening paper at the round table on nursing was presented by Grace G. Grey, principal, school of nursing, Jewish Hospital, St. Louis. Miss Grey's subject was "The Value of General Duty Nursing Service in the Hospital."

Miss Grey discussed the value of graduate nurse service to the hospital, to the public, to the school of nursing and to the nurse herself. She pointed out that the hospital that employs graduate nurses to supplement the services of the student group is a more stable organization than the one that relies on a shifting student service and that graduate nurses are absolutely essential in the work of special departments. If hospitals are to gain the respect and confidence of the public, Miss Grey said, all experimenting must be done away with and expert care given. This care can better be given by graduate nurses than by student nurses.

Student nurses can progress more rapidly, she emphasized, if they attend classes regularly, and if the staff is sufficient to supervise their work. Graduate general floor nurses should be available when students are in class. As for the nurse herself she may become a specialist, and with outstanding administrative ability she can attain a position of great responsibility.

"The Status of the Special Duty Nurse" was the topic next considered, the speaker being Claribel Wheeler, director, Washington University School of Nursing, St. Louis. The special duty nurse is somewhat handicapped by not having a well defined place in the hospital organization, Miss Wheeler asserted, and this fact creates countless difficulties both for the nurse and the hospital. The nurse is often dissatisfied and crit-



Rev. John Martin.

They are sometimes careless in dress and appearance, especially when on night duty; they are sometimes disloyal to the hospital, criticizing the administration, the personnel and the members of the medical staff. In conclusion Miss Wheeler summarized her points as follows: (1) The present status of the special duty nurse in the hospital is not a satisfactory one; (2) there is lack of proper supervision and control of the worker, whose work as a result is often unsatisfactory to the patient, the physician and the hospital; (3) hospitals are not entirely meeting their obligations to the special nurse in making adequate provisions for her comfort and well-being; (4) the general dissatisfaction on both sides should lead to serious study of the situation and an attempt to remedy it; (5) group nursing may be one solution of the problem and its advantages to the nurse are obvious: her time could be properly proportioned and there would be no idle moments; her salary would be constant, and if she proved herself a good nurse, steady employment would be assured.

Following Miss Wheeler, Emilie G. Sargent, director, Visiting Nurse Association, Detroit, presented the first part of a discussion on "Provision for Adequate Nursing Service for the Middle Class Patient." Miss Sargent's discussion was concerned with visiting nurse association work and hourly nursing in homes.

Hourly appointment service is being offered by

ical because she feels that no proper provision is made for her comfort and welfare and she ranks as an outsider. She cannot always get adequate supplies with which to work; her dressing and rest rooms are often noisy and unattractive and she frequently has to remain in the corridor during visiting hours. On the other hand, Miss Wheeler said, there comes from hospital executives criticism of the special. It is held that these nurses do not feel under obligation to conform to rules and are frequently a law unto themselves.

organizations to attract the person of moderate means, according to Miss Sargent, and is one definite way of decreasing nursing costs and at the same time increasing the amount of nursing used. Miss Sargent discussed the flexibility of visiting nursing service, saying that a private physician, clinic or hospital may order a nurse for any kind of case. The visiting nurse association, like the hospital, is no longer limited in scope but has broadened its service to the entire community. Part-time nursing in the homes not only will benefit the family purse but will give more nurses employment since more persons will engage nurses.

"Appointment service has come to stay," Miss Sargent declared, "and eventually it will serve as one means of reducing the cost of sickness when the public has learned to use it. That goal will be reached much more quickly if physicians and hospital administrators are sufficiently interested to inform patients about it, and to order it for their patients who can use skilled nursing as well or better by intermittent hourly doses than in daily continuous amounts."

The second phase of the subject, "Provision for Adequate Nursing Service for the Middle Class Patient," was presented by M. Della DeLong, director of nursing, Grace Hospital, Detroit, who described experiences with group nursing in the hospital during the last two years.

In Grace Hospital the group nursing scheme has been limited to two services—one comprising a service of thirty-two beds in small wards and the other a service of nine two-bed rooms on one floor. If special architectural arrangements are made for the department, a much broader service is possible, she said. The personnel for this department should be chosen very carefully, she said, and with several groups of nurses on duty continuously, the scheme should in no way detract from the work of special private duty nurses.

Advantages of group nursing in the hospital



Dr. Joseph R. Morrow.

were discussed by Miss DeLong as follows: Group nursing offers the patient of moderate means a special nursing service at a reduction of 45 to 65 per cent in cost; it affords the nurse steady employment, adequate vacation, reduction in hours of duty and an annual income exceeding the average special duty nurse; it enables the hospital to furnish special nursing service within the means of the salaried individual and ensures a continuous special nurse service for many patients who need individual attention.

The last discussion at this round table was given by Janet Geister, director at headquarters, American Nurses Association, New York City, on a central directory as a clearing house for nurses.

A modern, well organized registry has a number of important functions, she pointed out. It is the logical place in the community where the nurse registers for service, where her credentials are examined and her services graded according to her particular skill and qualifications.

The registry can be of assistance to the hospital by supplying nurses at once. In doing this, the nurses' credentials are important since untrained women often take advantage of the hospital's need saying that their credentials are lost. Good nurses are available through the central directory. All the hospital has to do is to call the registry. If it is well organized it will know where the good nurses can be found. The registry also lists the nurses' specialties so that if the hospital needs a nurse to help out in the operating or to perform other specific services she can be found immediately.

Such a registry, however, demands financial support. One way, according to Miss Geister, of bringing the hospital and the registry closer together would be for the hospitals to pay a membership fee to the registry.

Every department of the hospital was discussed in a unique round table conducted by Dr. Malcolm T. MacEachern, on Thursday morning. It was called "A Clinic on Hospital Administration" and there were no speakers assigned to the subjects discussed, the meeting taking the form of an open forum. The board of trustees and how they may best serve the community and the hospital; the organization of the hospital; the admission of patients, which included the location of the admitting department, its personnel and other pertinent points; the keeping of case records; clinical laboratory work; the function of the x-ray department; the proper dietary service; the social service department and the work of the social service personnel; various centralized services in the hospital; public relations in the broader sense and

other topics were discussed by a large number of administrators who were present. This form of round table proved of great value as those who attended were eager to discuss the questions.

The round table held for administrators of small hospitals was divided into six topics and great interest was shown by those who attended the meeting. G. W. Olson, superintendent, California Lutheran Hospital, Los Angeles, conducted the meeting and the first speaker was Lydia H. Keller, R.N., superintendent, Methodist Deaconess Hospital, Rapid City, S. D. Miss Keller spoke on "Responsibility of Accredited Standing." She stated that one of the duties of the superintendent was so to manage the hospital that it can be accredited by those rating bodies that now assign the standing of hospitals.

#### *Staff Membership Provokes Discussion*

Dr. Donald M. Morrill, superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich., was the second speaker, with a paper on "Single or Multiple Staff Membership." He discussed the advantages of having physicians on the staff who served no other hospitals and also the advantages of having physicians who were on other staffs. This question caused much debate among the members and for small hospitals it appeared that it was better to have single staff members than those who were on several staffs.

Dr. Paul Keller, executive director, Beth Israel Hospital, Newark, N. J., spoke on the obtaining of revenue from special departments and told of the experiences in Newark with this problem. This question also brought forth much discussion because it was the claim of many of those present that the special department should be run at a profit while others contended that the good of the patient was not best served when profit was the main motive of the special departments.

Daisy C. Kingston, superintendent, Somerset Hospital, Somerville, N. J., discussed the selection of the hospital help and the best methods of obtaining the best help.

Charlotte Janes Garrison, superintendent, Decatur and Macon County Hospital, Decatur, Ill., discussed wages in the hospital and systems of promotion and Ralph M. Hueston, superintendent, Silver Cross Hospital, Joliet, Ill., closed the session with a discussion of buying and storage. Mr. Hueston emphasized the importance of not overbuying and the elimination of waste through proper storage.

Dr. Joseph R. Morrow, superintendent and medical director, Bergen Pines Hospital, Ridgewood, N. J., presided over the meeting of the tuberculosis section, in the absence of its chair-

man, Dr. G. L. Bellis, superintendent, Muirdale Sanatorium, Wauwatosa, Wis. The secretary, Dr. H. J. Corper, National Jewish Hospital, Denver, was also unavoidably absent, and his duties were performed by Dr. Arnold Shamaskin, medical superintendent, Montefiore Country Sanatorium, Bedford Hills, N. Y.

Edgar A. Steubenrauch, architect, Sheboygan, Wis., gave an interesting paper on "Sanatorium Buildings," which was illustrated by a number of lantern slides of a new 100-bed sanatorium at Madison, Wis. The building, which contains four stories and a basement, was described and complete details of its arrangement and equipment were shown.

#### *Shows Development of Tuberculosis Buildings*

The discussion was opened by T. B. Kidner, New York City, who emphasized the fact so well exemplified by the paper and slides, that modern tuberculosis sanatorium buildings are hospitals, not mere boarding houses such as were considered sufficient some years ago.

Among other points brought out in the discussion were the following: (1) Except in the case of bedfast children requiring special surgical or medical care, children should not be housed under the same roof with adults; (2) in county sanatoriums, provision should be made for outpatient service since the county sanatorium should be the center for all antituberculosis activities in the community it serves; (3) patients should not be housed on the first floor with the medical and general administration offices and rooms, but it is often convenient to arrange a receiving section on the first floor; (4) personnel should not be housed in patients' building; (5) facilities for phototherapy should be provided both for heliotherapy and for lamp treatment; (6) loud speaker radios should not be installed, but every bed should have an outlet near it for an individual head set.

One speaker said he still believed that buildings for the tuberculous should not be more than two stories high; but this idea received no support. Since 80 per cent of sanatorium patients to-day are infirm cases, the same considerations that have led to the adoption of multi-story buildings for general hospitals apply to tuberculosis hospitals.

Dr. H. A. Pattison, superintendent, Potts Memorial Hospital, Livingston, N. Y., read a comprehensive paper on "Business Administration."

The paper was discussed by several sanatorium superintendents, and it was pointed out that it is often necessary for the sanatorium administrator to adjust himself to local conditions.



*Philip Vollmer, Jr., left, and Dr. E. R. Crew.*

An excellent paper on "Medical Administration" was presented by Dr. Arnold Shamaskin, who stressed the need for proper diagnosis, carefully kept records, close supervision of treatment and frequent reexaminations of each patient.

In the absence of Dr. Benjamin Goldberg, member and secretary of the board of directors, Chicago Municipal Sanitarium, his fine paper on "Sanatorium Objectives" was presented by Doctor Fremmel, one of the staff of the sanitarium. The discussion on this paper was opened by Dr. W. H. Ordway, physician in charge, Metropolitan Life Insurance Company's Sanatorium, Mt. McGregor, N. Y.

The following officers of this section were unanimously elected: chairman, Dr. Joseph R. Morrow; secretary, Dr. H. J. Corper (reelected).

The first speaker on the program of the small hospital section, Thursday afternoon, was Clarence H. Baum, superintendent, Lake View Hospital, Danville, Ill., whose subject was "Practical Methods of Financing the Small Hospital."

Mr. Baum's paper was divided into four sub-topics: plant and equipment, operation and maintenance, growth and developments and plans for paying off the hospital debt. Under the topic, plant and equipment, Mr. Baum suggested that

those in charge should work with the department heads as well as with the architect in order to route all services to save all the time and labor possible. Much time can be saved, also, if allied services are grouped together by rearranging old buildings rather than by waiting for new ones. The laboratory is most successful in giving service and in saving labor when it is adjacent to the operating room. The boiler room and laundry should be removed as far as possible from the patients' rooms.

Speaking of operation and maintenance, Mr. Baum said that the hospital must always be on the watch for better methods. Mr. Baum listed some of the ways in which he saves money. These include: using an automatic coal stoker that fires a 150 horse power boiler thus permitting the burning of the cheapest coal screenings and also saving the expense of an extra fireman; selling the hospital garbage instead of burning it; selling the cinders from the furnace to road builders and baling the waste paper.

Since 25 per cent of the hospital expense comes under the heading of general supplies and 25 per cent goes for food and 50 per cent for the pay roll, two other ways in which the hospital can save are on the food and the pay roll expenditures.

Concerning paying off the hospital debt, Mr. Baum pointed out two ways of getting ready money—by gifts and by using credit to borrow sufficient funds. Since gifts are not always forthcoming, a plan for paying on a loan from a sinking fund may be worked out. Another source of revenue is a ladies' aid, whose membership fees and the activities the members promote to raise money for the hospital are always helpful. Many hospitals are also selling annuity bonds to raise revenue, and are promoting an endowment fund as one of the surest ways of receiving funds.

#### *Financial Responsibility of the Community*

"How far is the community as a whole responsible for the financial support of its hospitals?" J. J. Weber, superintendent, Vassar Brothers Hospital, Poughkeepsie, N. Y., made this question the theme of his paper, which was the second read at this session. "Upon the answer that any given community gives to this question will depend in large measure the cost to any given patient of the hospital service he receives," Mr. Weber said.

The four functions of the hospital, Mr. Weber pointed out, are the care of the patients, the teaching of doctors, nurses and technicians, research into the manifestations of diseases, their causes and cures, and preventive work. An un-

derstanding of these functions shows how largely the hospital serves or stands prepared to serve not merely those persons who are patients in the hospital but the entire group of citizens, he said. Because of this the hospital should have the financial support of every citizen of the community.

These four functions of the hospital can best be accomplished through suitable buildings and adequate equipment, according to Mr. Weber, and the responsibility for providing the buildings and equipment rests with the citizens of the community, to any one of whom the hospital may at some time mean the difference between anxiety and reassurance, between a permanently crippled condition and a normal condition, sometimes even between life and death.

It is the responsibility of the community, he said, to see that the indigent sick are cared for by providing necessary funds for an endowment fund or by other means. For those patients who can pay part of their hospital bills, the community should accept the responsibility of making up the difference to the hospital. Whether the patient who is able to pay for all of his care or the wealthy patient, should be made to make up the deficit caused by the care of the free or the part-pay patient is an open question, he said.

#### *Modern Business Principles Urged*

The time is not ripe for hospitals to attempt to do business on the installment plan, Ernest G. McKay, superintendent, Arnot-Ogden Memorial Hospital, Elmira, N. Y., told those who attended this session. Mr. McKay's paper, "Hospitals and Modern Credit Business Practice," was third on the program. If hospitals would apply business principles to their credit departments, such as a definite follow-up system, complete credit information and personal collectors to call at the homes to see that hospital bills are paid when promised, credit losses could be greatly reduced, he explained.

Mr. McKay commended the idea of a personal collector, saying that he would no doubt get better results than the old way of mailing statements each month.

Mr. McKay gave four reasons why he thought the installment plan would not be successful for hospitals: (1) In the commercial world when the purchaser enters into a contract he knows in advance just what it will cost and he has planned his finances to meet the payments. This is not true in the hospitals except in maternity cases. (2) The commercial world deals with a concrete object that can be recalled if the purchaser fails in his payments. In the hospital a man cannot

very well be given back his tonsils or his appendix. (3) In the commercial world the purchaser is using the article he has bought while he is paying for it, and it is continually brought to his mind. In the hospital the patient is anxious to forget his illness and there is nothing to remind him of his obligation. (4) Hospitals rarely resort to legal action to enforce collection of their bills, since hospitals generally are community affairs, receiving bequests and gifts from philanthropic citizens and do not wish to give the impression that they are too commercial.

#### *"Grading" Returns Pour In*

The nursing section met on Thursday evening, when Carrie M. Hall, superintendent of nurses, Peter Bent Brigham Hospital, Boston, presided. Dr. May Ayres Burgess, director, Committee on the Grading of Nursing Schools, New York, opened the program and her address was eagerly anticipated. Doctor Burgess told about the sending out of the grading material and how it came back. The questionnaires were sent out the week of May 12, she said, and by the following Monday completed reports were received from 500 schools of nursing. By June 17, 1,365 reports had been returned, of the 2,220 sent out. The closing date for receiving these reports is July 1. During the summer the material will be analyzed and at the next meeting of the committee in the Fall Doctor Burgess hopes to be able to suggest the method of grading to be adopted. When the final analyses have been made a confidential report will go out to each school, to the superintendent of the hospital, to the superintendent of nurses, to the chairman of the board of trustees and to any person whose name has been given on a signed blank by the superintendent of the hospital. The confidential reports sent out will consist mostly of diagrams with explanatory text, each diagram being annotated to show where the particular school stands compared with other schools.

At the same time a report of the study will be released to the newspapers and magazines, without giving the standing of any particular school but giving the standing of different groups of schools.

"The fundamental characteristic of a nursing school faculty is that the nurses who compose it shall be educators who appreciate the present function of nursing and who know how to utilize the resources of their school and hospital to realize these functions." This was the theme of the address on "What Constitutes the Faculty of a School of Nursing?" given by Marian Rottman, director of nursing service, Bellevue and Allied Hospitals, New York City.

In the fields of administration and instruction, the supply of qualified nurses does not nearly equal the demand, she asserted. Better faculties indicate better curricula and better curricula mean more and better students.

Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, Ill., traced the rise in educational standards and its effect on schools of nursing and hospitals. Miss McCleery took the year 1900 as the starting point for her study and by quoting from announcements from various training schools of that year and the years immediately following showed that little emphasis was placed upon education by hospitals and schools at that time.

From a very elementary education required twenty-nine years ago, standards have been raised year by year until now there is a definite educational plan beginning with a foundation of basic subjects and advancing in a logical manner, according to Miss McCleery. In the twenty-two schools that contributed to the study, the candidate now must have been graduated from an accredited high school, or if she is a candidate for the degree-diploma course she must have completed acceptably at least two years of college work.

#### *Background of Experience Needed by Teacher*

Concerning the background of education and experience that the teacher in the school of nursing should have, the last speaker, Margaret Tracy, assistant professor, Yale University School of Nursing, New Haven, Conn., was emphatic in her statements that she must have a background of experience in as many as possible of the three nursing fields and especially in the field of public health and that she must have had definite training in educational principles and practice either in a college or a normal school.

The one inflexible requirement in the nursing school is that what is needed in practice must be taught, Miss Tracy said. When considering the preparation of nursing school teachers, both groups—the classroom teacher and the clinic teacher—must be included. Instructors whose time is spent in the classroom or laboratory are needed as well as those teachers who work with the student in the hospital wards, in the clinics of the dispensary or in the districts of visiting nurse associations. Rather than separate entirely the teaching from the hospital job, it is preferable to improve the equipment with which the teacher-supervisor comes to her work, to give her adequate assistance and to relieve her of many of the routine clerical and housekeeping duties that have hitherto absorbed much of her time.

## Dr. B. A. Wilkes Named President-Elect of Protestant Association

**M**ANY outstanding features, among them an excellent and well thought out program, brought a record attendance to the annual meeting of the American Protestant Hospital Association, held at the Traymore Hotel, Atlantic City, June 14, 15, 16 and 17. All of the sessions were well attended and most enthusiastic discussions followed the presentation of all papers. A report on vacations, sick leaves and other time off by employees was among the events of the week as well as the luncheon of the regional leaders.

On Saturday evening an unusual treat was enjoyed by the delegates when the banquet was held with the president, the Rev. J. H. Bauernfeind, presiding and E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, acting as toastmaster. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, was the song leader. The guests of honor were Dr. Louis H. Burlingham, director, Barnes Hospital, St. Louis, who

brought greetings from the American Hospital Association and Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, who spoke on "Signs of the Times in the Hospital Field." Doctor MacEachern gave a comprehensive description of the work that is being done in hospitals, of the improvements that are being made and of the ever increasing standards that are required. He essayed to look into the hospital of the future and lauded the association for the part it was playing in the upbuilding of the institutions in all parts of the United States.

Five other speakers, all of them delegates from Great Britain to the International Hospital Congress also addressed the diners. They were W. H. Harper, Wolverhampton, G. H. Hamilton, London, J. R. Mitchell, Chester, A. Griffiths, Ipswich, and Capt. W. Cockburn, Rugby. They expressed their deep appreciation of the many honors that had been bestowed upon them since coming to the United States and of the many kindnesses that



*Luther G. Reynolds, superintendent, Seattle General Hospital, Seattle, Wash., who becomes the active president.*



*The Rev. J. H. Bauernfeind, superintendent, Evangelical Deaconess Hospital, Chicago, the retiring president.*

had been given them by members of the Protestant Hospital Association.

On Friday evening a special meeting was held which was open to the public. At this time an address was delivered by Godfrey H. Hamilton, secretary, National Hospital, London, and the presidential address was given by the Rev. J. H. Bauernfeind. Mr. Hamilton explained much of the workings of British hospitals, of the work of the associations, and of the general health service that is being conducted in that country. He compared methods used in America and in Britain and his paper was of especial interest to all present.

The report of the nominating committee was heard on Monday morning, when it was announced that Dr. B. A. Wilkes, superintendent, Missouri Baptist Hospital, St. Louis, was chosen president-elect. Luther G. Reynolds, superintendent, Seattle General Hospital, Seattle, Wash., will preside during the coming year, having been elected president-elect last year.

#### *To Make Hospital Reports More Readable*

A report of the publicity committee, which will henceforth be known as the committee on public relations, was heard on Monday morning. It was recommended that a study be made of annual reports to the end that Protestant hospitals make their reports more readable and of more benefit to the general public.

The opening session on Friday started with devotions and an inspiring address entitled "The Healing Question" by Dr. Charles C. Jarrell, general secretary of the general hospital board, Methodist Episcopal Church South, Atlanta, Ga. Doctor Jarrell told of the fine work that had been done in religious hospitals for centuries but deplored faith healing as it is sometimes practiced by charlatans.

Doctor Jarrell was followed by John H. Olsen, formerly of the Bushwick Hospital, Brooklyn, who spoke on the standardization of supplies. Mr. Olsen advocated that Protestant hospitals of the country give some thought to standardization and to recommendations that will result in better buying and in more economic administrations. His paper was followed by an address by E. S. Gilmore entitled "Some Requisites for the Proper Conduct of a Hospital." Mr. Gilmore told many things that could be done by hospitals toward an improved service and stressed the point that besides the building and the equipment there was also to be considered the spirit in which the work was done.

Rev. N. E. Davis, secretary, Board of Hospitals, Homes and Deaconess Work of the Methodist Episcopal Church, then gave the report of the committee on vacation and sick leaves. He pre-

sented each one present with his report based upon a survey recently made among the members of the association in which it was shown that there was great lack of standards on the length of vacation and sick leave that should be allowed to various department heads and other personnel in the hospital.

There was attached to the survey recommendations of the committee both for vacations and sick leaves. Much credit is due to Doctor Davis and to A. G. Hahn, Deaconess Hospital, Evansville, Ind., for the work that they did in making the survey.

Dr. C. S. Woods, St. Luke's Hospital, Cleveland,



*Robert Jolly.*

closed the afternoon session with a round table at which Thomas Dawkins, managing executive, Park East and Park West Hospitals, New York City, Mary B. Miller, superintendent, Presbyterian Hospital, Pittsburgh, and Dr. B. A. Wilkes, superintendent, Missouri Baptist Hospital, St. Louis, were the speakers.

An enjoyable paper was given by May A. Middleton, superintendent, Methodist Episcopal Hospital, Philadelphia, on "The Responsibility of Departmental Supervisors."

On Saturday morning Dr. Frank C. English gave the report of the secretary-treasurer, and an inspirational address was delivered by the Rev. Luther G. Reynolds. These were followed by an address entitled "A Constructive Program for In-

dividual Health Instruction to Be Given in the Hospital," by Dr. J. C. Heibert, superintendent, Medical Mission Dispensary, Boston. Emily Loveridge, superintendent, Good Samaritan Hospital, Portland, Ore., read a paper on hospital nursing which was greatly enjoyed. Miss Loveridge's long experience both as a hospital director and a nurse brought authenticity to the paper and her admonitions were well received.

A round table on hospital nursing was conducted by the Rev. James E. Holmes, superintendent, Methodist Episcopal Hospital, Brooklyn, N. Y. Three speakers were on this round table. They were Martha Jane Avard, superintendent, Addison Gilbert Hospital, Gloucester, Mass., Gertrude Hog, superintendent of nurses, Allen Memorial Hospital, Waterloo, Iowa, and Mae Rodgers Bates, director of social service, Women's Hospital, New York City.

The program on Saturday afternoon opened with an excellent survey made by Dr. J. B. Franklin, superintendent, Georgia Baptist Hospital, Atlanta, Ga., entitled "What Is the Remedy for the Abnormal Charity Burden Forced Upon Hospitals in Admitting and Caring for Automobile Accident Patients?" Doctor Franklin presented many facts concerning this subject and then suggested that some legislative measure be taken similar to the workmen's compensation laws. He further suggested that a standard law should prevail in all of the states. His paper was discussed by Dr. H. F. Vermillion, superintendent, Southern Baptist Sanatorium, El Paso, Texas.

#### *Finances Are Thoroughly Discussed*

A. M. Calvin, business manager, Northwestern Baptist Hospital Association, St. Paul, Minn., then presented a paper on "Financing Capital Accounts."

The Rev. John E. Lander, financial secretary, Wesley Hospital, Wichita, Kan., then told how his institution operated under the budget system and proved that a much more businesslike administration resulted from the use of budgets. Paul H. Fesler, superintendent, University of Minnesota Hospital, Minneapolis, Minn., read a paper on "The Planning of Hospital Equipment and Furnishings." Mr. Fesler has recently equipped a new unit of his institution and he told of the steps that had been taken in selecting the right equipment for each department. His paper was followed by a round table conducted by Dr. A. O. Fonkalsrud, superintendent, Sioux Falls Hospital, Sioux Falls, S. D., and the following speakers were heard: Austin Shoneke, superintendent, New Rochelle Hospital, New Rochelle, N. Y., Dr. T. R. Ponton, superintendent, Illinois Masonic Hospital,

Chicago, and Robert Jolly, superintendent, Baptist Hospital, Houston, Texas.

Sunday was given over to devotional meetings.

The convention ended on Monday morning with several excellent addresses. Dr. W. S. Rankin of the Duke Endowment delivered an address on the "Hospital Problem of the Duke Foundation" and this was followed by a round table on "Winning the Public." The Rev. Thomas A. Hyde, superintendent, Christ Hospital, Jersey City, N. J., Robert Jolly, Houston, Texas, C. S. Pitcher, Presbyterian Hospital, Philadelphia, I. W. J. McLain, St. Luke's Hospital, Utica, N. Y., J. Dewey Lutes, Lake View Hospital, Chicago, and others participated.

### **Educational Aims for Nurses Are Discussed at League Meeting**

The National League of Nursing Education met in Atlantic City, June 17 to 21, and many of the meetings were concerned with hospital problems because, as one of the leaders expressed it, "all the aims of the nursing league are interwoven with those of other hospital workers, to make a safe place where sick people may be restored quickly to health."

The league program during the week in Atlantic City considered special questions that the league has been studying during the last months. In the joint meeting with the American Hospital Association on Tuesday evening nursing education from the standpoint of various officials of the hospital was discussed. The education committee, at its special meeting, talked over methods of stimulating and carrying out continued education of head nurses.

To present its ideals more graphically an exhibit was prepared and displayed by the league. The exhibit presented certain concrete situations in which the nurse needs a definite scientific knowledge as a background for the necessary care she must give to the patient. Model wards were shown in contrast to those places in which patients were cared for before the Nightingale system of nursing was introduced everywhere. Constantly changing slides gave those who saw the exhibit an understanding of situations in a nurse's life in which her usefulness is decidedly enhanced by a scientific foundation to her preparation. Posters and charts of achievements and the kinds of care given by nurses of varying academic preparation for the nursing courses were a part of the exhibit.

Guests were present for the meeting from New Zealand, Sweden, Belgium, Finland and Canada.

## Child Health Problems of Many Nations Discussed

**P**ROBLEMS encountered in child health and welfare work and the progress made in preventive measures both in the United States and abroad were discussed at the annual meeting of the Children's Hospital Association of America held at Atlantic City, June 20, in connection with the convention of the American Hospital Association and at Philadelphia June 21.

As president of the association Dr. Howard Childs Carpenter, Philadelphia, presided at the opening meeting, when Dr. Louis H. Burlingham, president of the American Hospital Association, extended greetings from the hospital convention.

As first speaker on the program Dr. René Sand, president, International Hospital Congress, told of the preparation and orientation of child welfare work in Europe. He declared that Denmark leads in the social program for child welfare and child protection. He explained the health insurance systems of the various countries and declared that preventive work in the United States never will be entirely successful until some health insurance is made obligatory.

Grace Abbott, chief, Children's Bureau, Washington, D. C., speaking on "The Children's Hospital and Child Welfare," stated that there can be no well rounded program without a fine knowledge of the children's hospital and child welfare movement and without a general economic and social background for the care of children. She urged close cooperation between all agencies having to do with child health or welfare work.

Miss Abbott declared that the children's program is universal, and not intended only for the poor.

### *Hospital Must Cooperate With Other Agencies*

Dr. A. Graeme Mitchell, chief of staff, Children's Hospital, Cincinnati, was the last speaker on the morning program. The subject of his address was "The Children's Hospital in Its Relationship to the Child Health Program of the Community."

That the children's hospital shall do its best for the sick child is its first and most important contribution to child welfare, said Doctor Mitchell. Its task does not cease there, however, but in some way it must provide for convalescence and help to guard and maintain the child's

health. In maintaining health the hospital may well be responsible for its own clientele, according to Doctor Mitchell. Classes of instruction for mothers, nutrition classes, posture classes, the follow-up and the occasional visit to the presumably well child are ways of aiding in the health program. Often the hospital will cooperate in such work with agencies and associations that have as their primary functions one or the other of such activities. The hospital can take part as far as is feasible in any citywide plan that has to do with child welfare.

### *Doctor Carpenter Re-elected President*

At a short business meeting held in the afternoon Dr. Howard Childs Carpenter was reelected president of the association and Bena M. Henderson, superintendent, Milwaukee Children's Hospital, was reelected secretary-treasurer. Trustees chosen include Dr. Isaac A. Abt, Chicago, Robert E. Neff, Iowa City, Iowa, Florence Potts, Albany, N. Y., Elizabeth Pierce, Cincinnati and Dr. James B. Cutter, San Francisco.

Nell Clausen, Milwaukee Children's Hospital, led a discussion on general and special diets in a children's hospital, emphasizing the opportunity to teach proper diet habits.

The part-time staff with permanent chief of staff was described as the ideal arrangement for a children's hospital by Dr. J. Claxton Gittings, medical director, Children's Hospital, Philadelphia. Dr. Stanley J. Seeger, Milwaukee Children's Hospital, spoke on the children's hospital from the surgeon's point of view and emphasized the delay caused by cross infections.

Dr. Horace H. Jenks, St. Christopher's Hospital for Children, Philadelphia, told of the convalescent care given in Philadelphia. He advised placing convalescents in private homes rather than keeping them in hospitals. Byrd Boehringer, superintendent, Shriners Hospital, Greenville, Pa., described the care of crippled children in Shrine hospitals.

Delegates devoted all day Friday to a tour of Philadelphia hospitals, visiting the new Hahnemann Hospital, the Babies' Hospital of Philadelphia, Children's Heart Hospital of Philadelphia, Philadelphia General Hospital, and the Shriners Hospital for Crippled Children.

## National Register Soon to Function for Occupational Therapists

THE thirteenth annual meeting of the American Occupational Therapy Association, held at Atlantic City, N. J., from June 16 to June 19, in conjunction with the annual convention of the American Hospital Association, proved to be one of the best attended and most successful meetings in the history of the association.

A well diversified program of papers, addresses and discussions was provided for each session, and the keen attention of the members and the many visitors who were present throughout was exceedingly gratifying to the program committee.

### *Patients' Work of High Quality*

The exhibit of patients' work was of even higher quality than in preceding years, and proved to be unusually attractive to the large number of persons who attended the sessions of the American Hospital Association and its affiliated groups, as well as to the members of the association. The delegates to the International Hospital Congress from foreign countries showed keen interest in the exhibits, and the chairman of the exhibits committee and her assistants were kept busy answering numerous inquiries regarding the organization and methods of work in the occupational therapy departments of the fifty-two American hospitals and other institutions represented by the exhibits.

Through the splendid cooperation of the American Hospital Association the exhibit was excellently displayed in the great central hall of the new Atlantic City auditorium. A room was also provided for the meetings, and the executive secretary of the American Hospital Association, Dr. Bert W. Caldwell, was untiring in his efforts to provide every facility for the convenience and comfort of the members, guests and visitors present at the meetings.

The annual meeting of the board of management was held at the Hotel Chelsea, June 16, prior to the opening of the general sessions, June 17. The opening session was called to order promptly at 2 p.m. on June 17, by the president, Dr. C. Floyd Haviland, superintendent, Manhattan State Hospital, New York, and the proceedings began with a solemn invocation by the Rev. Dr. Henry Mellen, Atlantic City, N. J. An address of welcome to New Jersey was then delivered by

the Hon. Wm. J. Ellis, commissioner, State Department of Institutions and Agencies, Trenton. Commissioner Ellis, in his address, bore testimony to the help and inspiration that had been afforded by the officers and members of the American Occupational Therapy Association in the development of curative occupations in the various state institutions under the direction of his department.

The president of the New Jersey Hospital Association, Dr. Joseph R. Morrow, medical director and superintendent, Bergen Pines Hospital, Bergen County, Ridgewood, N. J., then presented the greetings of his association. Doctor Morrow further said that, as a hospital administrator, he had observed with keen interest the remarkable growth of occupational therapy and the growing interest taken in the annual meetings of the association. He also expressed his deep interest in the news that the association was about to establish a national register of qualified occupational therapists. "Had such a register been in existence a few years ago," said Doctor Morrow, "a somewhat unfortunate experience that I had when I attempted to introduce occupational therapy into my hospital would not have occurred. I am confident that the worker I engaged on the strength of her alleged qualifications would not have been admitted to a national register such as your association proposes to establish."

### *Doctor Caldwell Brings Greetings From A.H.A.*

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, extended the hearty greetings of his association, and congratulated the members on the increasing recognition that is everywhere being given to the need and value of curative occupations in the rehabilitation of the sick and the disabled in all types of hospitals and related institutions.

Doctor Haviland responded to the several greetings and gave a masterly presidential address. At the outset he emphasized the great debt the association owed to the secretary-treasurer, Mrs. Eleanor Clarke Slagle, for her faithful efforts in the cause of occupational therapy and in the upbuilding of the association of which she was one of the founders. Doctor Haviland also expressed his high appreciation of the great services ren-

dered to the association by his predecessor in office, T. B. Kidner, New York, during his five years as president of the association.

President Haviland referred also to the great services rendered by Dr. W. R. Dunton, Jr., as editor of the association's official organ, *Occupational Therapy and Rehabilitation*. Each of the three members named was one of the original founders of the association and had also served as president.

#### *A Review of Association Activities*

In reviewing the work of the association since the last annual meeting, Doctor Haviland called attention to the large and increasing number of associations and organizations with which cooperative relations were maintained by the association. He emphasized especially the great value that had accrued to the association from its relations with the American Hospital Association, and he also made particular reference to the help that had been afforded the association and its individual members by the American Conference on Hospital Service through its chief activity, the Hospital Library and Service Bureau. He said that under the able direction of Donelda R. Hamlin, the bureau had been helpful in providing up-to-date bibliographies of occupational therapy literature and current periodicals and in lending on request package libraries dealing with various phases of hospital work and curative occupations.

Doctor Haviland reported with pride that the association had been formally invited to take part in the first International Congress on Mental Hygiene to be held in Washington, D. C. He also stated that the association had been asked to nominate one of its officers as a member of the organization committee of the congress and that Mrs. Eleanor Clarke Slagle had been duly appointed as a member of the committee. He also called attention to the labors of the committee on national registration, whose report would be presented at a later session, with the full endorsement of the board of management and a recommendation for its adoption.

Mrs. Carl H. Davis, chairman, standing committee on teaching methods, which has been making an exhaustive study of the existing standards and future needs of the training schools, presented a comprehensive report that included an analysis of the theoretical and practical work of the schools and of the practice training in the hospitals. While the report indicated that the minimum standard of six months' practice training should be increased as soon as it is deemed feasible, no change in that requirement was recommended for the present. The committee recom-

mended, however, that the minimum period of eight months' theoretical and practical training be increased to nine months. The report included some interesting particulars of the development of four-year courses in several of the colleges by which students are enabled to undertake the regular studies leading to a bachelor's degree, as well as to work for a diploma in occupational therapy. A vote of thanks was tendered to the committee for its excellent report.

Mrs. Eleanor Clarke Slagle, secretary-treasurer, then presented her report, which had also been adopted by the board of management as its annual report which the board is required by the constitution to submit to the members at each annual meeting. The report was exceedingly thorough and indicated that the various activities of the association are constantly expanding and that its opportunities for services are increasing as the years go by. One of the most interesting features of the report was the long list of national associations, governmental agencies, private foundations and various other organizations and groups with which the association has established and maintains cooperative relations. The association also can feel just pride in the report of the secretary-treasurer of the assistance to various foreign countries in establishing occupational therapy which has been given by the national office either by correspondence and literature or through personal contacts with visitors from abroad who have come to study our American institutions and methods.

#### *Membership Drive Is Under Way*

Of even greater importance and interest to the members was that part of the report which dealt with the special work undertaken by the various state and local occupational therapy associations, in cooperation with the national office, in making a survey of the extent to which curative occupations are used by hospitals and by other institutions in agencies throughout the country. Although all the surveys have not yet been completed, the information contained in the reports that have been received and tabulated in the national office has already proved valuable.

The state and local associations have also undertaken a drive for new members with gratifying results. The association need more funds for its work and, as was pointed out in the report and also in the president's address, an increase in the membership is one way to obtain the much needed funds for the extension of the association's activities. The report of the activities of the placement service showed an encouraging growth and it also emphasized the success of the methods

developed in its operation. Every request for a worker is considered in the light of the special requirements of the position to be filled. Only those candidates are nominated whose record of training and qualifications indicate that they can adequately fulfill the duties of the position. Reference was also made to the requests received from time to time by the national office for help in making surveys of the needs of hospitals and other institutions and agencies with the view of developing new schemes of curative work or of improving and expanding occupational therapy departments or activities already in existence. In this field of the association's activities, the reports referred to the service given through several recent surveys by Mary E. Shanklin, of the national headquarters' staff. The report on membership showed a gratifying net increase due in large measure to the efforts of the state and local associations. The finances of the association are in a sound condition but more funds are required to enable the association to comply with the increasing demands for service.

At the conclusion of the report, Louis I. Haas, Bloomingdale Hospital, White Plains, N. Y., spoke in eulogistic terms of the services of Mrs. Eleanor Clarke Slagle to whose efforts he attributed in large degree the success and growth of the association. The report was adopted with a hearty vote of thanks to Mrs. Slagle.

The report of the finance committee was next presented by the chairman, Mrs. F. W. Rockwell, and included a budget of expenditures for the next fiscal year of the association. Reference was made to the two special funds raised by the members and friends of the association. The need of further funds was stressed, particularly for the establishment of the national register. The report was adopted with thanks to the committee.

#### *Presidents Are Honor Guests at Tea*

After the close of the session, the members proceeded to the Hotel Chelsea, where a tea was given by the association in honor of the presidents of the various state and local occupational therapy associations. This was an exceptionally pleasant function and was followed by an informal conference of the presidents of these associations.

The first paper on Tuesday morning, June 18, "Occupational Treatment for Children at Riley Memorial Hospital, Indianapolis, Ind.," was presented by Winifred Conrick, chief occupational therapist of the hospital. The paper was illustrated by stereopticon pictures and gave a comprehensive view of the program of curative work and allied therapeutic activities of the hospital. The discussion on this paper was opened by Mrs. John

A. McDonald, chairman, occupational therapy committee, Junior League, Indianapolis, which maintains the occupational therapy department in the Riley Memorial Hospital. Mrs. McDonald, in her paper stated that the promotion of occupational therapy in the hospitals of Indianapolis forms the chief activity of the Junior League of that city.

#### *Indianapolis Junior League Activities*

The league's status is that of sponsor and comptroller of occupational therapy in the three Indiana University hospitals. The league assumes all expenses for equipment, general maintenance, upkeep and salaries. Its members also assist the professionally trained occupational therapists in the several hospitals, each volunteer aid being qualified for the work by a course of twelve weeks' training given by Miss Conrick. This year, thirty-eight Junior League members served regularly as aids in the Riley Hospital. The occupational therapy departments in the hospitals are an integral part of the medical school of the university and all the curative work is carried on under medical prescription and direction. Miss G. R. Lermitt, director, St. Louis Occupational Therapy Training School, St. Louis, testified to the valuable opportunities for practice training for her students that are afforded by the occupational therapy departments carried on by the Junior League of Indianapolis.

The next paper was presented by Dr. J. William Hinton, assistant professor of surgery, New York Post-Graduate Medical School and Hospital, New York City, and was entitled "Occupational Therapy in the Treatment of Joint Fractures." Mary E. Merritt, director of occupational therapy, Bellevue Hospital, New York City, was associated with Doctor Hinton in the presentation of the paper, and on opening the discussion offered some valuable practical suggestions arising out of her daily experience. Doctor Hinton's paper was scholarly and scientific, and included clear and helpful particulars of the methods of treatment followed with the large number of fracture cases that are referred to the occupational therapy department in Bellevue Hospital. The appropriate treatment for different types of fracture was described. Doctor Hinton also emphasized that occupational treatment is started early in all types of fracture cases, with excellent results. The paper was also discussed by Dr. Mandell Shimberg, Reconstruction Clinic, Syracuse, N. Y., who emphasized the value of a judicious combination of physiotherapy and occupational therapy in fracture cases. He also stated that in his experience occupational therapy treatment often pre-

vents the post-traumatic swelling so characteristic of fracture cases.

In the unavoidable absence of Major Harry D. Offutt, chief of the occupational therapy and physiotherapy departments, Walter Reed General Hospital, Washington, D. C., his paper on "Occupational Therapy in a Military General Hospital" was presented by Alberta Montgomery, supervisor of occupational therapy, Walter Reed Hospital. Major Offutt outlined the history of curative occupations in U. S. Army hospitals from the day that the late General Wm. Gorgas introduced it into the army hospitals during the World War. Curative occupations are to-day an integral part of the treatment in all U. S. Army hospitals and are used in each department of the hospitals. In addition to a description of the general procedure and methods of his department, Major Offutt included in his paper valuable remarks on the medical and scientific reasons which led to the general adoption of treatment by occupations in the army hospitals. Miss Montgomery opened the discussion and also answered questions submitted from the floor. Dr. B. W. Carr, chief of the occupational therapy and the physiotherapy section, U. S. Veterans Bureau, also spoke. He pointed out that it was often difficult to convince medical men of the value of occupational therapy in hospitals for acute cases where the average duration of a patient's stay was less than two weeks. Marion Tabor, New York Hospital Visiting Committee, State Charities Aid Association, pointed out in reply that at Bellevue Hospital the doctors in the different services were now quite convinced by the experience of the past few years that occupational therapy is of value in a general hospital and are now fully in favor of its use whenever possible. T. B. Kidner called attention to the fact that although curative occupations had been used generally in their war hospitals by most of the nations engaged in the World War, the United States was the only one of those nations which continued its use in army hospitals in times of peace. This is a matter for just pride to American occupational therapists.

#### *Doctor Howland Opens Afternoon Session*

The opening address at the afternoon session was given by Dr. Goldwyn Howland, M.R.C.P. (London) of Toronto, president, Canadian Occupational Therapy Association, and dealt practically with "Occupational Treatment in Mental Diseases." Doctor Howland also referred to the progress made in the training of occupational therapists. The training course maintained by the University of Toronto is to be lengthened to three years and will include instruction in physio-

therapy for those workers who intended to specialize in orthopedic work. Doctor Howland also said that he thought that although every worker must have a broad, general training in the use of curative occupations in all types of illness and disability, occupational therapists will become specialists in different lines just as in the medical profession.

Dr. Horatio M. Pollock, director, statistical bureau, State of New York Department of Mental Hygiene, Albany, then gave an exceedingly valuable and informative paper on "The Need, Value and General Principles of Occupational Therapy Statistics."

The next paper, "The Contribution of Occupational Therapy to Child Guidance Work," was read by title in the unavoidable absence of its author, Dr. Clarence M. Bonner, superintendent, Danvers State Hospital, Hathorne, Mass.

#### *Dr. René Sand Honored at Banquet*

"Occupational Therapy in Schizophrenia" was the subject of a remarkable paper by Dr. Henry I. Klopp, superintendent, Allentown State Hospital, Allentown, Pa. As a statement of the tremendous advantages that have accrued from the use of occupational therapy, combined with habit training in the treatment of the large proportion of schizoid cases present in most mental hospitals, Doctor Klopp's paper was helpful and inspiring. With the further help afforded by music, calisthenics and properly organized recreation, occupational therapy is resulting in the almost total disappearance of the so-called "Back Wards" in which regressed, untidy and turbulent patients were formerly kept. The general discussion that followed was opened by Gladys Carter, chief occupational therapist, Allentown State Hospital, Allentown, Pa.

The annual banquet of the association was held the evening of June 18 in the Westminster Hall of the Hotel Chelsea and attracted a large attendance of members and friends. The president, Dr. C. Floyd Haviland, presided over the gathering and asked T. B. Kidner to introduce the distinguished guest of honor, Dr. René Sand, of Brussels, Belgium, technical counselor to the International League of Red Cross Societies, Paris, France. Mr. Kidner referred to the great help that had been afforded by Doctor Sand in the development of reconstruction activities in the war hospitals of Canada and the United States from the experience of Belgium and by Doctor Sand's visit to the United States in 1918. Mr. Kidner also referred to the signal and well deserved honor that had been conferred last week on Doctor Sand by his appointment as director-general

of the newly formed International Hospital Congress.

Doctor Sand expressed his great pleasure at being present and at having the opportunity to meet some of his old friends again. His inspiring address was filled with many delightful sparks of wit and eloquence. Speaking from the breadth of his experience of hospital and social work in practically every civilized country, Doctor Sand contrasted the different methods that obtain in the older countries of Europe and in this great, new nation of America. Although the methods may be dissimilar, and in backward countries more paternalism must be exercised by their governments, the goal was the same everywhere—the betterment of conditions for the sick and the disabled and for humanity in general. He congratulated the American Occupational Therapy Association on its work. He said that, as an international worker, he had learned with deep interest and pleasure of the help the association had been able to give to other countries in the development of occupational therapy in their hospitals and institutions. Prolonged applause and a rising vote of thanks greeted Doctor Sand at the conclusion of his address.

#### *Reminiscences of the Early Days*

President Haviland then called upon another distinguished guest, Doctor Howland, Toronto, president, Canadian Occupational Therapy Association, who made one of his characteristic witty addresses with humorous reference to some of the problems that have arisen in consequence of the close contiguity of Canada and this country.

At the conclusion of Doctor Howland's address, which was enthusiastically applauded, President Haviland remarked that he felt sure the members would not forgive him if he did not call upon their secretary-treasurer, Mrs. Eleanor Clarke Slagle, for a few words. Mrs. Slagle, in response, indulged in some reminiscences of the early days of the association, and said that if ever a dream came true the dream of the founders of the association had been realized, a fact that was amply demonstrated by the large attendance and the deep interest in all the meetings.

At the close, many members were personally presented to Doctor Sand whose charming personality has endeared him to every one with whom he has come in contact on this and his six previous visits to this country.

The program for the morning session on June 19 consisted of a series of papers and addresses, highly scientific but exceedingly practical and illuminating, on the rehabilitation of physically disabled persons by means of curative occupations.

The first paper, "The Industrial Curative Workshop and Its Importance to the Community," was prepared by Leslie Wood, chairman, shops committee, Industrial Workshops, Rochester, N. Y., but was presented by Elizabeth K. Wise, director of occupational therapy in the Industrial Workshops. From small beginnings some years ago, these workshops have grown until to-day they have become a community enterprise of great importance and value. The principal reason for the success of this enterprise is the cooperation that has been developed. Industrial leaders, employment officers and plant physicians in Rochester's many industries, the hospitals, clinics, many private physicians, welfare agencies and socially minded citizens are all keenly and practically interested in the work of the shops. In consequence, the expert workers in charge have been helped and encouraged in every possible way in their efforts to furnish this much needed service for an industrial community.

The shops are of two types: (1) an occupational therapy department and shop to which patients are referred by out-patient clinics, physicians and welfare agencies which also provides the occupational therapy in the County Hospital; (2) a workshop that provides sheltered remunerative employment for persons seriously handicapped by illness or the results of accidents. Work is also provided for disabled persons confined to their homes. Some interesting case records were given and Miss Wise answered questions on the work of the shops. The discussion on this paper was opened by Gladys Pattee, director of occupational therapy, Mayo Clinic, Rochester, Minn., who gave interesting details of the work in her department.

#### *Occupational Therapy in Milwaukee*

Marjorie Taylor, advisory director, Junior League Curative Workshop, Milwaukee, presented a paper, illustrated by moving pictures, on the work that is being done for industrial and other accident cases in the League's Workshop. The complete steps from a patient's admission were described and illustrated. These included measurements of the extent of the impairment of movement in the injured member or members of the body and the various forms of treatment employed. Physiotherapy and occupational therapy are used in conjunction. The moving pictures of the various curative measures employed for different types of disability were most instructive. Several surgeons present discussed this and other papers and stressed various warnings and practical suggestions that were made by the readers of the papers. The need of thorough training in anatomy, physiology and kinesiology on the part

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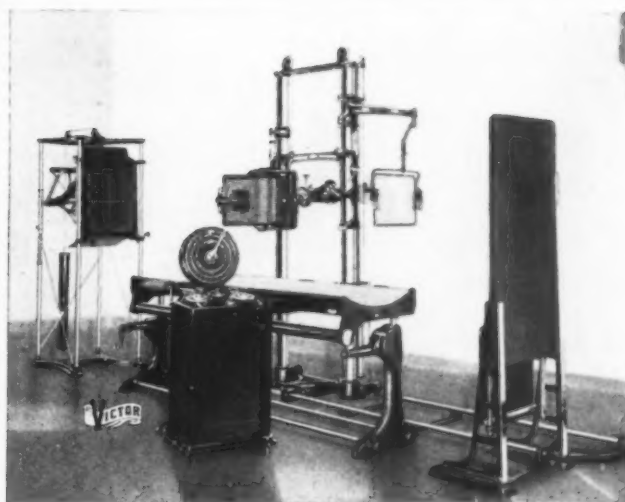
As its name implies, this X-ray unit is absolutely safe against any possibility of operator or patient coming in contact with electric current on any part of the apparatus—the first complete, combination X-ray outfit in the world to incorporate this feature.

This development, the culmination of years of research and engineering efforts, answers the long standing query of roentgenologists the world over: How can it possibly be accomplished? It is now a realization.

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Unequalled facilities for research and experimental engineering have made possible this epochal development.

The Victor Shock Proof X-Ray Unit is submitted in the sincere belief that it is a direct contribution to the X-ray art, in that it offers a means of doing the work more quickly and conveniently, with absolute safety, and with assurance of consistently better end results—contributing toward more certain diagnosis and a better medical service that must obviously follow.



- |                                      |   |
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| Shock proof.                         | Not affected by altitude or humidity.                       |
| Silent operation.                    | Introduces a new principle of control.                      |
| Compact.                             | Consistent results.   |
| Self-contained.                      | Complete diagnostic service.                                |
| Greater flexibility.                 | Unit construction permits variation according to specialty. |
| Increased diagnostic range.          | No danger around ether, when setting fractures, etc.        |
| Eliminates overhead system.          |   |
| Longer tube life.                    |   |
| Same tube used over and under table. |   |



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ORGANIZATION

of the worker in such curative workshops was clearly shown by Miss Taylor and other readers and speakers.

A splendid paper, characterized both by its scientific and practical value and entitled, "Some Experimental Studies in Functional Restoration at the Reconstruction Clinic," (Private Reconstruction Clinic, Rochester, N. Y.) was given by Dr. Mandell Shimberg, the head of the clinic. Marian Clark, director of occupational therapy in the clinic, showed a series of interesting pictures which illustrated the case records and description of the methods given by Doctor Shimberg in his paper.

#### *Visitor From Porto Rico Gives Address*

"Some Experiences in a Private Occupational Therapy Clinic" was the title of an exceedingly interesting paper presented by Martha Emig, St. Paul, Minn. The need for such a clinic had been pointed out and Miss Emig outlined in her paper clearly and instructively the various steps of its development. As other speakers had done, Miss Emig stressed the need for the establishment of cooperative relations with official industrial rehabilitation agencies as well as with hospitals, out-patient departments, private physicians, visiting nurses' organizations and other welfare agencies.

The morning session concluded with a charming address by Mrs. Diaz, public health department, San Juan, Porto Rico, who has been studying occupational therapy in hospitals and other institutions in this country with the view of introducing it in Porto Rico. Mrs. Diaz expressed her deep gratitude to the various physicians and chief occupational therapists who had afforded her every facility for study in the various hospitals visited by her. She also expressed her special indebtedness to Mrs. Slagle, who had done so much to make her visit to the United States so interesting and profitable.

The concluding session of this annual meeting was held in the afternoon on June 19 and was well attended. The secretary-treasurer reported that 226 members and fifty-four guests had been registered and that twenty-eight states, the District of Columbia, Porto Rico and two foreign countries were represented at the meetings. By request of the standing committee on teaching methods, its report was accepted as a report of progress and the committee was asked to continue its investigations as to the need for changes on the minimum standards of training. The chairman of the committee on national registration, T. B. Kidner, presented the committee's report. The report which recommended a few minor

changes on the draft scheme issued to every member of the association in November, 1928, was unanimously approved and adopted. The national register will therefore be established as soon as the necessary funds are available.

Mrs. F. W. Rockwell, chairman finance committee, informed the members of the contributions already promised to the registration fund. Representatives of several state and local associations who were present pledged generous contributions to the fund. A number of individual members also promised donations. The report of the standing committee on publicity and publications was presented by its chairman, Dr. Wm. R. Dunton, Jr., and was adopted.

The report of the committee on resolutions presented by its chairman, Louis A. Haas, was adopted with acclamation. The report recommended that the sincere thanks of the association be tendered to all who had contributed to the great success of this thirteenth annual convention. Special mention was made of Dr. René Sand, for his splendid address at the banquet, to the American Hospital Association and its executive secretary, Dr. Bert W. Caldwell, for the excellent arrangements made for the association's meetings and exhibits, to Doctor Howland, president, Canadian Occupational Therapy Association, for his fine address, to the Hon. Wm. J. Ellis, commissioner, New Jersey State Department of Institutions and Agencies, for his address of welcome and to the president of the New Jersey Hospital Association, Dr. Joseph R. Morrow, for his cordial greetings and for the gift to each member of the A. O. T. A. present at the banquet of a souvenir booklet issued by his association.

Special thanks were also voted to President Haviland and the other officers of the association and to the chairman and members of all standing and special committees.

#### *Doctor Haviland Is Again Chosen President*

The report of the committee on nominations, presented by Marjorie B. Greene, chairman, was unanimously adopted, and the following officers and members of the board of management were duly elected: president, Dr. C. Floyd Haviland, New York City; vice-president, Dr. B. W. Carr, Washington, D. C.; secretary-treasurer, Mrs. Eleanor Clarke Slagle, New York City. Of the five members of the board of management whose terms of office expired at this meeting, Mrs. Carl H. Davis, Dr. Wm. R. Dunton, Jr., and Geraldine R. Lermitt were reelected. The two new members elected are Mrs. Esther Hill Roberts, president, California Occupational Therapy Association, and Beatrice Lindberg, St. Paul, Minn.

## No Argument need be added

"The known qualities of unsweetened Evaporated Milk—its sterility, its ready digestibility and uniformity of composition—are distinct advantages which recommend it for general use as milk for infants."

Mc KIM MARRIOTT, M. D.  
*Archives of Pediatrics, March, 1929, p 135*

That is the conclusion of Dr. Marriott after a feeding experiment covering a period of fourteen months and involving more than 1400 babies.

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JOSEPH BRENNEMANN, M. D.  
*Journal of The American Medical Ass'n, Feb. 2, 1929, p 364*

Dr. Brennemann so describes his experience with Evaporated Milk for sick babies at Children's Memorial Hospital, Chicago.

NO argument need be added to such evidence from such well recognized authorities.

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sale at every grocery store at a cost generally less than that of ordinary milk.

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## NEWS OF THE MONTH

### Surgeon Gives \$1,000,000 to Presbyterian Hospital

A gift of \$1,000,000, the first contribution to a \$6,000,000 expansion fund now being sought, has been presented to the Presbyterian Hospital, Chicago, by Dr. and Mrs. Arthur Dean Bevan.

The gift was announced by Doctor Bevan, noted surgeon and former president of the American Medical Association, at a dinner for the faculty and alumni of Rush Medical College held at the Auditorium Hotel, June 11. Doctor Bevan has been professor of surgery at Rush Medical College since 1902 and chief surgeon at the Presbyterian Hospital for many years.

At the conclusion of an address wherein he sketched the plans for the expansion of the hospital, including a clinic modeled after the famous Mayo Brothers' clinic at Rochester, Minn., Doctor Bevan announced the \$1,000,000 trust fund.

In predicting the future development of the hospital Doctor Bevan pictured Chicago's medical center as including Cook County Hospital, Presbyterian Hospital, the University of Illinois Medical School and hospitals and other institutions all in one sector.

For the Presbyterian Hospital Doctor Bevan predicted a new power plant, a completely equipped clinic, a children's pavilion, a maternity building, an addition to the nurses' home, and a new urological department with 700 beds in the general building.

### Two Plants in Philadelphia Plan Merger

The Woman's Hospital of Philadelphia and the West Philadelphia Hospital for Women have applied for a charter to merge, according to announcement in the *Journal of the American Medical Association*.

The Woman's Hospital building, which has been at 2137 North College Avenue for sixty-eight years, will be disposed of, and a new hospital will be erected on the site of the West Philadelphia Hospital.

### Will Provides for Establishment of Hospital

Provision for the establishment and maintenance of a hospital that will be open to persons of all creeds and will maintain as many free beds as the income will allow, is made in the will of the late Thomas M. Fitzgerald, prominent Catholic philanthropist of Lansdowne, Pa., who died May 13.

The will values the personal estate at "\$200,000 and upward" and the real property at "\$50,000 and upward," but the real value of the estate is said to be several mil-

lion dollars. The bulk of the estate is left to Mrs. Fitzgerald, at whose death the Lansdowne home is to be turned into a hospital known as Mercy Hospital. The entire estate is then to be liquidated and used for maintenance of the institution.

### Baltimore Philanthropist Gives Fund to Help Patients

A fund of \$1,000,000 has been set aside by Frederick Bauernschmidt, a Baltimore philanthropist, to aid patients who are unable to pay the full cost of their medical care but are willing to pay a part of the cost.

The income of the fund will be divided among eleven Baltimore hospitals for use in the care of patients of moderate means during the next twenty years, according to the *Bulletin of the American Hospital Association*. After twenty years the principal also will be distributed to those institutions, in proportions varying from one-twentieth to one-fifth.

### Cornerstone Placed at Hospital for Tuberculous Children

The cornerstone of the hospital for tuberculous children at Alto, Ga., sponsored and financed by the Masonic orders of Georgia, was placed recently at an impressive ceremony. Besides prominent Masons, state officers and members of the legislature were in attendance.

Contributions to the hospital fund, collection of which was directed by Raymund Daniel, grand master, totaled \$83,433.

### Employment Program Recommended for Mental Patients

The subcommittee on employment of the New York City Committee on Mental Hygiene has recommended a program providing for the employment of mental patients, according to a report published in a recent issue of the *S. C. A. A. News*. At present cardiac, handicapped and tuberculous patients are being looked after by the various employment and social agencies but no adequate steps have been taken in behalf of the mental patients.

The report made by the subcommittee includes recommendations for the establishment of a sheltered shop for mental cases; the assignment at each state hospital of a full-time social worker to carry on placement work; the increased utilization of private and general hospitals and institutions of all types as places for employing mental cases in need of close supervision and sheltered environment; utilization of industrial training available within the state hospitals for recoverable cases rather than for



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## News of the Month

chronic cases, as a method of effecting a speedier re-entrance into industry after hospitalization, and the establishment of an employment service for mental patients in the community who do not need placement in sheltered shops.

### Ohio Dietetic Association Holds Annual Meeting

The eighth annual meeting of the Ohio Dietetic Association was held in Columbus, May 14 and 15, with Myrtle Thornton presiding.

The program arranged by the Columbus dietitians proved both instructive and entertaining and an informal meeting of Ohio dietitians was planned for members who will attend the American Dietetic Association convention in Detroit next October.

The following officers were elected for next year: president, Myrtle Thornton, The Christ Hospital, Cincinnati; vice-president, Mary Lacey, City Hospital of Akron; secretary, Bess Gattton, Robinwood Hospital, Toledo, and treasurer, Eva Ylvisoker, Children's Hospital, Cincinnati.

### Indianapolis Hospital Solicits Gifts for Expansion Program

Active solicitation of gifts in the Indianapolis Methodist Hospital million-dollar expansion fund appeal was started recently. Four gifts totaling \$300,000 were subscribed through preliminary work.

Many opportunities have been afforded for memorial gifts and donors will be allowed to specify a definite unit to be created by their gift. Bronze tablets commemorating the name of the donor, or some name designated by him, will be erected in each memorial unit. Opportunities will be presented to memorialize entire floors, departments and single units.

New hospital facilities included in the expansion program for which the fund is being raised include the new service unit housing the x-ray, laboratory, surgical and maternity departments, a new 200-bed wing providing additional general hospital beds and the new home for nurses.

### Preliminary Work Starts on Texas Children's Hospital

Preliminary work on the construction of the Texas Children's Hospital at Dallas has been started with acquisition of a site near the crippled children's hospital with which it will work in close cooperation, the *Bulletin of the American Hospital Association* states.

The land has been purchased and presented as the gift of a prominent Texas business man. The hospital will cost \$600,000 and will have an endowment of \$1,000,000. It will treat all ailments of children not connected with broken bones and will be placed at the disposal of

physicians throughout the state, not only for the treatment of their own patients, but for research and study of the latest developments in pediatrics.

The institution will be a nonprofit, nonsectarian hospital and will be open to children of the Southwest on a basis of complete equality, regardless of financial ability. One-half of its 100 beds will be set aside for totally free service and will be maintained by the million-dollar endowment fund.

### Plans for New Tuberculosis Buildings Well Under Way

Preparations for breaking ground for the new tuberculosis buildings at Grasslands Hospital, Valhalla, N. Y., are well under way, according to announcement in *The Link*.

The building for adults will have accommodations for 190 beds, with special provisions for incipient, moderately advanced and infirm cases. The children's building will have sixty beds and will have facilities for detention, preventorium and active cases.

The buildings will be entirely fireproof. Although they will be separate from the main buildings of the hospital, they will be connected by passages so that the central kitchen, laboratories and x-ray department in the main building will serve both.

### New Board Members Elected

The Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York, one of the fifty-nine member institutions of the United Hospital Fund, has announced the election to its board of managers of Dr. G. Canby Robinson, dean, Cornell University Medical School, and C. Stanley Mitchell, chairman of the board, Bank of the United States.

### Mental Medicine Memorial Fund Honors Noted Psychiatrist

Establishment of the Thomas William Salmon Memorial announced recently by the Hon. George W. Wickersham, honorary chairman, gives national and international recognition, for the first time, to the scientist who makes the greatest outstanding contribution of the year in the field of mental medicine.

The memorial honors the late Dr. Thomas W. Salmon, former professor of psychiatry, Columbia University, and medical director of the National Committee for Mental Hygiene.

The plan provides for a series of lectures to be given in various cities in the United States under the auspices of accredited scientific, medical or educational organizations, Doctor Wickersham announces. Provision also will be made for the publication and distribution of the lectures from year to year in order to make possible the

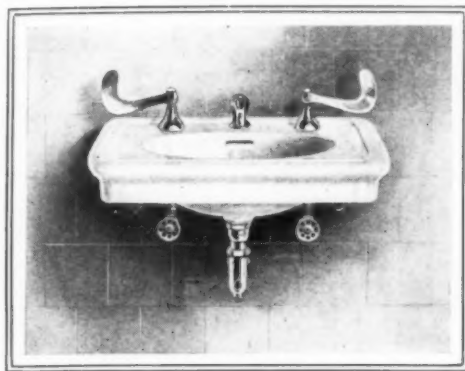
150 Pounds Pressure



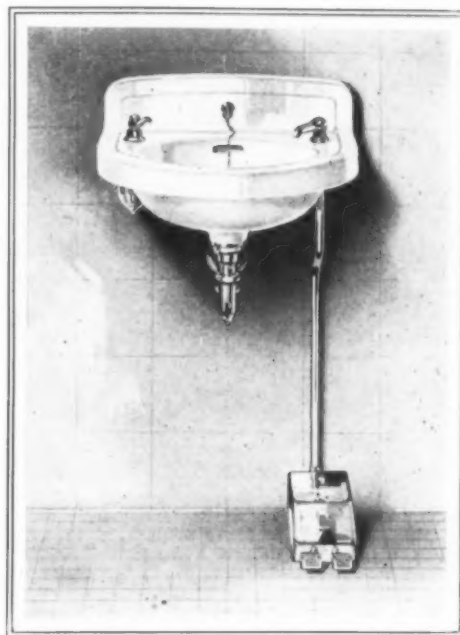
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Her great genius, her almost masculine vitality, and the vision of the men she had seen lying on vermin covered blankets, dying of neglect and gangrene, led her to accomplish much. She it was that awakened the world to the horror of countenancing such conditions.

Yet to others must be given a share of the credit of bringing hospital sanitation to its present state.

For many years Crane Co. has labored to devise a complete line of fixtures and fittings that would answer the purpose of sanitation and comfort in wards, in wash up rooms, in kitchens, and in operating rooms. The vast number of modern hospitals that have installed its products stand as mute testimony to the success of its labors.

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## News of the Month

maximum use of scientific knowledge gained annually through the expenditure of millions of dollars on research and study in the field of psychiatry and mental hygiene by state departments, universities, foundations and individuals.

The administration of the memorial fund is to be vested in the New York Academy of Medicine. The initial fund of \$100,000 for the establishment of the memorial is being contributed by Doctor Salmon's friends and associates and by laymen actively interested in the fields of mental and nervous diseases.

### Hospital Building Campaign in Detroit Is Over-Subscribed

The Associated Buildings Campaign, Inc., with which Grace Hospital, Detroit, Mich., was affiliated to the amount of \$1,850,000, was successfully completed recently with an excess subscription of nearly \$200,000, according to announcement made by the hospital.

The board of trustees has authorized the director and one or more members of the board to visit two or three recently constructed hospitals in Boston, New York and Philadelphia for the purpose of studying new developments in special hospital construction.

### Chicago Dietitians Hold Picnic Supper and Meeting

A picnic supper featured the meeting of the Chicago Dietetic Association held June 19 at the Chicago Municipal Tuberculosis Sanitarium.

Following the supper Dr. Benjamin Goldberg, secretary of the board of trustees of the sanitarium, gave a talk on "Diet in Tuberculosis."

### Hospital for Crippled Adults at Memphis Is Dedicated

Dedication of the \$200,000 Hospital for Crippled Adults recently completed at Memphis, Tenn., was held June 3.

The hospital is the gift of B. B. Jones, Barryville, Va., who gave the entire fund for the new building that has housed the institution since its removal last December from the old Presbyterian Hospital building where it was founded.

### Huge Center for Mental Patients Under Construction Near New York

A hospital building project which, when completed, will comprise eighty buildings with accommodations for 10,000 patients and 1,500 employees, is now under way near Brentwood, N. Y., where a new state hospital for the treatment of mental ailments is being constructed.

The hospital, to be known as the Pilgrim State Hospital in honor of Dr. Charles Winfield Pilgrim, famous specialist of mental diseases, will be the largest in the world. The cost will be approximately \$30,000,000 and the buildings will occupy a 400-acre tract.

The construction program, it is believed, will require about six years for completion. The building group will include the following departments: administration, reception group including complete diagnostic clinical facilities, medical surgical unit similar to a modern general hospital, four continued treatment groups, occupational therapy and preindustrial units, recreation and assembly hall, utility group comprising laundry, bakery, storehouse, maintenance shops, salvage shop and power house, and quarters for staff nurses and other employees.

The first building is now under construction with a total of 150 skilled mechanics at work. When the building program is further along the total of mechanics and laborers will be from 400 to 600 daily.

### New Veterans' Hospital to Be Located Near Lexington

The new veterans' hospital to be located near Lexington, Ky., will be under construction before the summer is over, according to announcement from the United States Veterans' Bureau, Washington, D. C.

The title to the 291 acres of land upon which the hospital will be built has just been approved by the Department of Justice.

The hospital will include fourteen buildings and will have a capacity of 350 beds.

### Government Seeks Information on Sheet Lengths

Representatives of the manufacturers, distributors and consumers of hospital and institutional cotton textiles met at the Department of Commerce, Washington, D. C., June 10, and developed a simplified practice recommendation on these products that was afterwards approved by more than 80 per cent of all three branches of the industry.

Included in that recommendation was the following resolution which was unanimously adopted:

"The conference recognized that consideration for comfort and sanitary and economic reasons have guided the present day practice toward the use of the 108-inch length of sheet. It directs that the standing committee study the desirability of adopting this length as standard and also consider the benefits of standardizing on equal depths of hems at the top and bottom of the sheets."

In conformity with this resolution the standing committee is now desirous of considering whether the 108-inch length should be recommended as the single standard length for hospital and institutional use and whether it should recommend equal depth of hems at top and bottom of sheet. In order to obtain this information the committee has issued questionnaires to hospitals throughout the country.

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## News of the Month

### Increased Tariff on Surgical Instruments Passes House

The bill providing for an increase in the tariff on surgical instruments from 45 per cent ad valorem to 70 per cent ad valorem, has been approved by the United States House of Representatives and now lies before the Senate.

Relief from this threatened increase, and prevention of an increase in the price of surgical instruments that will surely follow an increased tariff, can come now only from the Senate, the *Journal of the American Medical Association* points out.

"The makers of surgical instruments, who are primarily responsible for the proposed increase in tariff, have laid great stress on the fact that hospitals are the chief purchasers of surgical instruments and have endeavored to create the impression that such institutions will be able, without embarrassment, to pay more for surgical instruments than they are now paying.

"Protests from hospitals may be expected, therefore, to carry great weight, particularly if accompanied by exact figures showing the hospital's financial condition in relation to the demands on it for services," the *Journal* states.

An article in the April issue of *THE MODERN HOSPITAL* presented a table showing how the higher tariff would affect prices and quoting at length from a letter written by importers of surgical instruments showing upon whom the burden of such an increase would fall.

### South Dakota Hospital Group Holds Convention

The third annual convention of the South Dakota State Hospital Association was held at Watertown May 20 and 21 with a representative attendance from all parts of the state.

Dr. Percy Peabody, president of the association, welcomed the delegates and gave the opening address, outlining the benefits of such an organization. The secretary's report showed that the majority of the larger hospitals in the state have become affiliated with the association. Hospital taxation and county poor work were discussed at an open forum.

At the afternoon session addresses were given by Dr. Donald Smelzer, president of the Minnesota State Hospital Association, who spoke on "Some Vital Administrative Problems," and Sister M. Raphael, superintendent, McKennan Hospital, Sioux Falls, who spoke on "The Relation of the School of Nursing to the Hospital." Doctor Smelzer also discussed x-ray films, citing the dangers of improper storage.

In the evening delegates were entertained at a dinner given by the Watertown hospitals at the Lincoln hotel.

Three interesting addresses were presented Tuesday morning. D. L. Braskamp, superintendent, Lincoln Hospital, Aberdeen, spoke on "Hospital Publicity," C. W. Carlson, superintendent, Moe Hospital, Sioux Falls, talked on "Business Methods," and M. Amberg, University of Minnesota, spoke of public health work.

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, who was to have given the principal address at the convention, was unable to attend. His place was filled by Paul Fesler, superintendent, University of Minnesota Hospital, Minneapolis, who discussed various phases of hospital management.

The following officers were elected at the afternoon session: president, D. L. Braskamp, Lincoln Hospital, Aberdeen; vice-president, Dr. R. S. Westaby, Madison; secretary-treasurer, Sister M. William, Aberdeen; trustees, Clyda Lusk and E. W. Anderson.

Committees appointed by the president included: convention committee, D. L. Braskamp, Dr. R. S. Westaby, Sister M. William, Sister M. Raphael and B. Anderson; legislative, E. W. Anderson, C. W. Carlson and Sister Luitgard; constitution and rules, Miss Olson, George Campbell, Dr. H. Bartron; membership, Dr. R. S. Westaby, Miss Anderson and Sister Basilia.

### Superintendents of Iowa Hospitals Form State Association

Organization of the Iowa Hospital Association was perfected at a meeting of superintendents held June 1 at Des Moines.

Fifteen hospitals were represented by twenty-two superintendents and other officials. Dr. Bert W. Caldwell, executive secretary, American Hospital Association, was present and assisted in the organization of the association.

Officers and trustees were chosen as follows: president, Robert E. Neff, University of Iowa, Iowa City; first vice-president, George L. Rowe, superintendent, Polyclinic Hospital, Des Moines; second vice-president, G. T. Notson, superintendent, Methodist Hospital, Sioux City; secretary, Harold A. Grimm, superintendent, Finley Hospital, Dubuque; treasurer, R. A. Nettleton, superintendent, Iowa Methodist Hospital, Des Moines; trustees, Robert E. Neff, R. A. Nettleton and Harold A. Grimm; for three-year terms, Sister M. Benedicta, Mercy Hospital, Des Moines, and Clinton F. Smith, superintendent, Allen Memorial Hospital, Waterloo; two-year terms, Mary L. Elder, superintendent, Burlington Hospital, Burlington, and Mrs. Emma Lucas Louise, Jennie Edmundson Memorial Hospital, Council Bluffs; one-year term, Rev. Karl Rest, superintendent, Evangelical Deaconesses Home and Hospital, Marshalltown, and Nita M. Isaacson, superintendent Kossuth Hospital, Algona.

### A Cooperative Registry for Record Librarians

A cooperative registry for hospital medical record clerks and medical stenographers everywhere has just been sponsored by the Philadelphia Association of Record Librarians. It is intended primarily as a placement bureau for standardized workers. It will be run on a cooperative basis and not as a money making organization. The Bryn Mawr Hospital Medical Records Department, Bryn Mawr, Pa., will furnish details to those who may be interested.

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## Personals

MARY H. PATERSON has been elected superintendent of the Lawrence General Hospital, Lawrence, Mass., to succeed IDA WASHBURN, resigned. For five years MISS PATERSON has served in a teaching capacity at the Rhode Island Hospital, Providence, R. I., and before that held the position of superintendent in the Newport Hospital, Newport, R. I.

MILDRED J. HOLMES, Portland, Me., has been elected superintendent of the Carrie F. Wright Memorial Hospital, Newport, N. H., to succeed ANNA I. DONOVAN, acting superintendent since the resignation of DOROTHY C. BATES. MISS HOLMES is at present night supervisor, Eye and Ear Hospital, Portland.

CLARA A. BARBOUR, superintendent, Kittanning General Hospital, Kittanning, Pa., has resigned. She is succeeded by MARY MCCORMICK, formerly night superintendent, Sewickley Valley Hospital Association, Sewickley, Pa.

WILLIAM J. FINN, superintendent of the Conemaugh Valley Memorial Hospital, Johnstown, Pa., for the past six years, has resigned to become superintendent of the Memorial Hospital at Cumberland, Md.

GLADYS BUCKHOLT, R.N., is now superintendent of the Knox County Hospital, Knoxville, Tenn.

EMMA WENITH has become superintendent of the Flower Hospital, Tulsa, Okla.

DR. JOHN M. O'CONNOR is now superintendent of the New York County Penitentiary Hospital, New York City.

LEONA D. GREENE, R.N., has become superintendent of the Essex General Hospital, Newark, N. J.

HENRY DUDERSTADT is the new superintendent at McCleary Sanitarium, Excelsior Springs, Mo.

W. A. DEERHAKE is now superintendent of the Wisconsin State Prison Hospital, Waupun, Wis.

DR. R. J. ALEXANDER is the new superintendent of the Salt Lake County Hospital, Salt Lake City, Utah.

REV. THEO. STOECKER is now superintendent of the Emmanus Home for Epileptics and Feeble-Minded, St. Charles, Mo.

MOIR P. TANNER, superintendent of Mary Imogene Bassett Hospital, Cooperstown, N. Y., for the past year, has resigned. He will be succeeded by FRANK E. BROOKE, New York.

DR. PAUL D. CRIMM, Hartford, Conn., has been elected superintendent of the Boehne Tuberculosis Hospital, Evansville, Ind., to succeed DR. GEORGE E. MILLS, resigned. Doctor Mills will remain with the hospital as consulting physician.

E. B. BROOKS, managing officer of the Jacksonville State Hospital, Jacksonville, Ill., has resigned to enter private business in Newton, Ill. His successor has not been named.

MARY A. HUMPHREY has become superintendent of Oklahoma Hospital, Inc., Tulsa, Okla.

DR. E. T. OLSEN, formerly head of Englewood Hospital, Chicago, has been named superintendent of the Detroit Receiving Hospital. He succeeds DR. THOMAS K. GRUBER, who resigned to become superintendent of Eloise Hospital and Eloise Infirmary, Eloise.

DR. GEORGE S. AMSDEN, director of the psychopathic department, Albany Hospital, since 1924, has been appointed to the position of professor of psychiatry, New York Post-Graduate Medical School and Hospital. By virtue of his position, DOCTOR AMSDEN becomes director of the Max G. Schlapp Memorial Mental Hygiene Clinic, which will be reorganized and extended.

MRS. LILLIAN M. MAVITY, R.N., formerly superintendent of the Blackford County Hospital, Hartford City, Ind., has become superintendent of the Howard County Hospital, Kokomo, Ind. MARY E. GROSS succeeds MRS. MAVITY at Hartford City.

DR. M. L. DRYFUS, formerly assistant medical director, Jewish Hospital of Brooklyn, Brooklyn, N. Y., has been appointed director of the Beth Moses Hospital, Brooklyn.

DR. JOHN A. HOUSTON, superintendent, Northampton State Hospital for the Insane, Northampton, Mass., and former assistant physician, Worcester State Hospital, retired the last of June.

CORNELIUS S. LODER, who became associated with the Pottsville Hospital, Pottsville, Pa., several months ago to reorganize the hospital, has been elected superintendent of the institution.

DR. HARRY A. STECKEL has been appointed superintendent of the Newark State School for Mental Defectives, Newark, N. J. For some time DOCTOR STECKEL has been director of clinical psychiatry of the Binghamton State Hospital, Binghamton, N. Y.

DR. JOSEPH CLEMENT CLARK, for thirty years superintendent of the Springfield State Hospital for the Insane, Sykesville, Md., has been relieved of work because of illness. In appreciation of his long service he has been appointed superintendent emeritus and arrangements have been made for him to continue living in his present home at the hospital. DR. EDWIN P. BLEDSOE, medical officer in charge of United States Veterans' Hospital No. 105, North Chicago, Ill., and formerly superintendent of the Arkansas State Hospital, has been appointed to succeed DOCTOR CLARK.

MABEL CLENDENEN, formerly superintendent, Kenwood Sanitarium, Philadelphia, and recently engaged in public welfare work in New York State, has been chosen superintendent of the Bradford Hospital, Bradford, Pa., to succeed MRS. MARY P. WALLACE, resigned.

JOSEPH LANGLOIS is now superintendent of the Union Hospital, New Bedford, Mass.

JOSEPH J. WEBER, who recently resigned as superintendent of Grace Hospital, New Haven, Conn., has become superintendent of the Vassar Brothers' Hospital, Poughkeepsie, N. Y.

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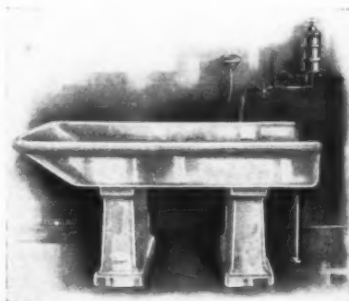
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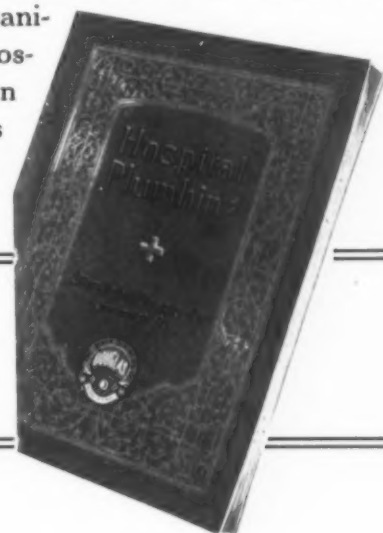
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## NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,  
Director, School of Nursing, Presbyterian Hospital, Chicago

# How Shall Candidates for Schools of Nursing Be Selected?

By C. RUTH BOWER, A.M., R.N.

Director, School of Nursing, Western Pennsylvania Hospital, Pittsburgh

THE strategic place for formulating a code of ethics for nursing is in the training school. The material, therefore, that the training school accepts determines to a great extent just what the standing of the nursing profession will be in relation to that of other professions.

Before admitting students to training schools for nursing we must understand what their positions and responsibilities are to be in the cooperative machine of life. The qualities of a nurse that lead to success and social efficiency are comparable to those of successful men and women in other positions. Just as leaders in law, medicine and education recognize certain qualities as essential to success in their fields, so we, the leaders in nursing, need to sense the attributes and equipment that are distinctive in the successes in our field.

### *What Characteristics Are Desirable for Nurses?*

We know that health, energy and ambition are factors in every human endeavor. We know also that manual skill is an important factor in the craft of a sculptor, surgeon, architect and builder. Physique and voice are important to the actor. Technical skill and originality play a large part in the success of the scientist. By studying the lives of leaders in the field of nursing we ought to find outstanding characteristics that are potent in making a successful nurse. The weaknesses frequently mentioned as limitations of a nurse's success are lack of education, lack of thrift, lack of health and lack of moral background. We hear much, perhaps too much, of the weaknesses of nurses, but for our constructive program, let us stress the strength, particularly the source of that strength, of the nurses who have made superior records.

Let us analyze the background of leaders like Florence Nightingale, Rebecca Strong and Jane Delano. Let us see what characteristics they had that are common to other women who are leaders in the nursing profession to-day. Characterizing them all are industry, will power and honesty. We note their intelligence, stability, culture and personal charm. We mark, too, their self-control, their self-respect, their sincerity and courage. And in their exercise of all these necessary and splendid qualities one

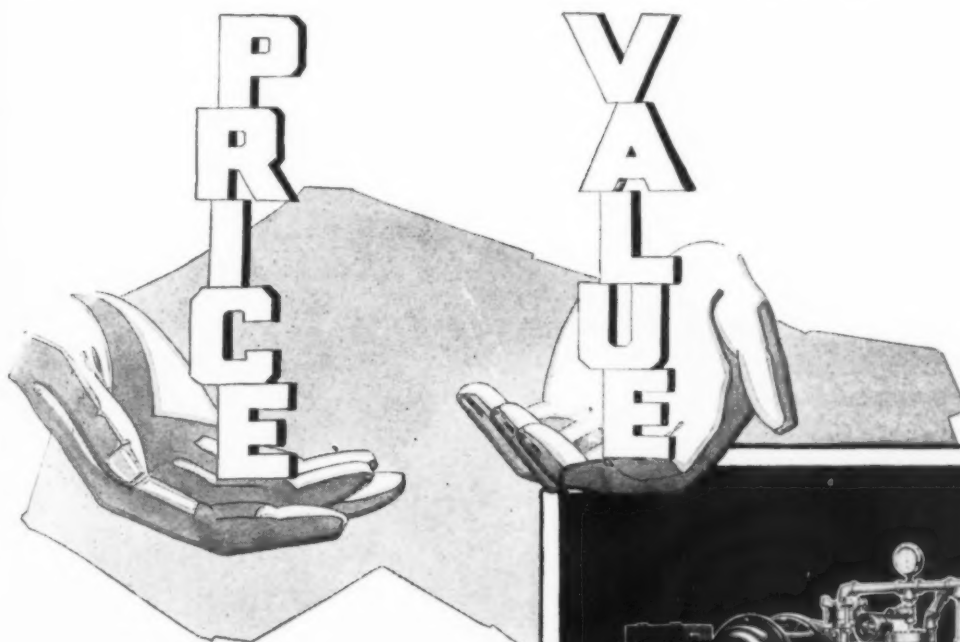
is conscious of the presence of a deep human sympathy combined with charitableness and toleration.

Noble characters? Yes. High standards? Yes. But are they too high for the nursing profession? Are all professions demanding as much? Compare the requirements for entrance into teaching, law and medicine.

Let us take Pennsylvania as an example. In Pennsylvania every teacher in the public schools must present first, evidence of good health; second, evidence of good moral character; third, evidence of having completed a stated amount of work in education after graduating from a high school. This educational requirement has a minimum of seventy hours of work in education, six of which must be practice teaching—the amount of work required demands about two years of college training. Dr. Charles H. Judd, in his discussion of adult education, in Louisville, said in part: "There is a striking parallelism between the problems that confront the members of the nursing profession and those that confront the members of the teaching profession. The nurse is charged with the care of the sick. Teachers are charged with the responsibility of training children. But if care of the sick and the training of children are to become entirely effective, they must be performed in such a way as to make the whole community intelligent. Nurses come in contact with members of the family, and teachers come in contact with parents of pupils. Nurses will be most successful if they know how to deal with both patients and families, just as teachers are most effective when they know how to deal with both pupils and parents."

### *Fixing the Entrance Requirements*

In examining the requirements for admission to the study of law in Pennsylvania, we find that many of the law schools require two years of college preparation, although the state law demands but a high-school education. Before a student can be admitted to a law school in Pennsylvania he must be recommended as a person of good moral character by four lawyers living in his community. One of these four will accept the preceptorship of the student since no lawyer is permitted to accept the preceptorship at any one time of more than three stu-



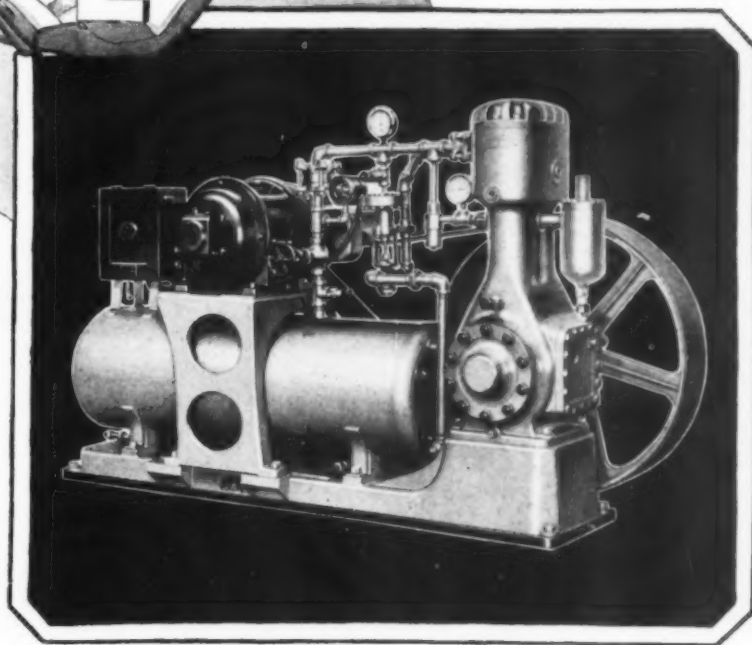
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dents of law. The chosen preceptor in cooperation with the other three lawyers is responsible for the moral standing and integrity of the student. At the expiration of the student's professional training these four men must report in person, and in writing to the state board of law examiners the moral responsibility and development the student has made before he is permitted to take the state examination for the practice of law. This is mentioned to call attention to the great stress that the profession of law puts upon moral responsibility.

In the last twenty-five years the medical profession has increased its requirements to a marked degree. It now requires two years of premedical college training, four years in a medical school and one year of internship in a hospital.

### *What Requirements Does Profession Demand?*

What does the nursing profession demand in the form of entrance requirements? In an attempt to answer this question, questionnaires were sent to sixty training schools of nursing in Pennsylvania. These questionnaires asked about the physical, educational and moral qualifications required of persons applying for admission.

Thirty-five of the sixty questionnaires were answered.

The first question asked concerned educational requirements.

Four schools had a minimum requirement of one year of high school. Twelve schools had a minimum requirement of two years of high school. Two schools had a minimum requirement of three years of high school. Seventeen schools had a minimum requirement of four years of high school. All of these schools reported that an effort is being made to make high-school graduation the minimum requirement for admission to their schools.

The second question asked concerned physical requirements.

Twenty-five schools require recommendations from family physicians; most of these require a second examination after entrance. Five schools require a dentist's certificate. Three schools require an oculist's certificate. Twenty-five schools require a vaccination certificate. Ten require a Schick test. Six schools require a Dick test. Four schools require immunization for typhoid fever. One school requires a radiograph of the chest. A few failed to state whether or not a physical examination is required. The report would indicate that in general, schools are particular about the physical equipment of their applicants.

The third question concerned moral qualifications.

Nineteen schools require a recommendation from a minister. Six schools require a recommendation from a teacher. Two schools require three letters from citizens of the community. Two schools require two letters from citizens of the community. Seven schools require one letter of recommendation. Most of the training schools report that they study their students most carefully during preliminary training, and do not lay much stress or dependence upon recommendations.

The fourth question was: Do you require a personal interview before students are admitted as probationers?

Sixteen schools require a personal interview. Two schools require a personal interview with the mother. Some schools feel that an interview is desirable but impossible.

A subquestion asked was: Do you find the student of eighteen years more difficult to train in practical nursing than the mature woman?

Twenty-four schools report that the eighteen year old girl is less difficult to train. Twelve schools report that the eighteen year old girl is more difficult to train.

On the question of theoretical nursing twenty-nine schools report that the eighteen year old girl is more easily taught. Six schools report that the eighteen year old girl is more difficult to teach. To this question most of the training schools reported that, while the younger student is not more difficult to train, it is harder for her to accept responsibility that is placed upon her. Some schools also report that the lack of success in a student is many times due to a lack of interest in the subject.

In the questionnaire, the fifth question was: Do you visit homes before or during the probationer period? To this question no answer in the affirmative was received. However, some interesting comments were received as follows: (1) "Our hospital has neither time nor money for this investigation." (2) "No. But, may I have a report as to what other training schools are doing in this respect?" (3) "No. Is it possible that any training school in the state makes this investigation?" (4) "Will you please let me know if this is customary any place?" (5) "No. But we write to parents reporting on the progress of students and get very good responses." (6) "No. We do not have provision in our budget for traveling expenses, nor do we have time for it."

The sixth question was: Do you give mental tests?

Three schools answered in the affirmative. Thirty-two schools answered in the negative.

The result of this survey suggests the need of the standardization of entrance requirements and the necessity of sane and efficient methods of estimating the qualities of the applicant. Before any conclusions are drawn from the answers to the questionnaires, attention is called to an extract from Dr. May Ayres Burgess' book, "Nurses, Patients and Pocketbooks."

She says: "Physicians feel that probably the real difficulty is sometimes found in the unwise selection of the students in training. Physicians also believe that only women of good education and good social background should be permitted to enter schools of nursing. Patients report that education and good breeding are lacking in many nurses."

### *Unqualified Students Sometimes Accepted*

Assuming that these criticisms are justifiable, does it not seem possible that too frequently principals of schools of nursing, through pressure of work brought to bear by the hospital, accept students who do not have the higher personal qualifications and sounder and more fundamental training required. These persons, under the supervision of the training school authorities, carry on in a mediocre way the technical nursing service, but after they are thrown on their own resources they do not have the broad culture and viewpoint demanded of the nursing profession.

The replies to the questionnaires have demonstrated that the training schools in Pennsylvania are striving toward higher standards. Many schools require an examination of physical fitness during preliminary training. This is as it should be, for the physical and mental strain thrust upon students in training schools for nursing is tremendous, and only the best can carry the load.

The educational requirements have developed immeasurably. There is evidence that training schools are making an effort to accept in their schools only high-school graduates. But should we not take a step and have a mental evaluation made of each student before or during her preliminary period? Is there a way to measure character qualities such as responsibility and truthfulness? If we could find such a measure might we lessen the number of students who leave the school through incompetency or who fail after graduation?

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There are trained psychologists to-day who can assist us in attempting these measures. Not all schools, however, feel that they are ready or able to use the services of a trained psychologist, but there is one available way of understanding our applicants better, a means we have overlooked in developing our training schools. This way is the investigation of the family background and life development of prospective students.

If we can select for our training schools, girls who are strong physically, who have a well rounded education plus the experience of having lived a healthy emotional life, we are more apt to develop nurses who will follow their profession happily and efficiently. In turn they will reflect credit upon the schools from which they come. Our aim should be to graduate nurses better fitted intellectually and emotionally to cope with life, nurses who will become citizens, whose actions in their professional and public lives will not be influenced by badly solved emotional problems and whose judgment will not be warped when they face reality.

We need more information about the individuals whom we propose to train. We should aim to get a mental picture of each girl as she has lived, up until the time she presents herself to us as an applicant for admission. Health certificate, school records, and recommendations from two or three persons cannot tell the whole story. We need to know why nursing has attracted the girl. We need to know what she enjoys. We need to study the social background and personality make-up as well as intellectual capacity and physical condition, so that we may know with some degree of safety if our course in training will so meet the abilities and emotional needs of the girl that we will turn out at the end of three years a well integrated citizen as well as a first-class nurse.

#### *Study of Individual Talents Necessary*

To understand an individual we must discover as far as possible whether she has special talents, and wherein her limitations lie. We must try to learn what her special interests are and why she has them. We cannot understand the girl until we know something of her home life, her friends, her joys, her sorrows, her responsibilities. If we can get some light upon these things and from it can determine what is cause and what is effect, we then begin to "learn" the person whom we propose to "teach."

Dr. Edward Howard Griggs once said, "Every vocation has its own dangers, and these are great in proportion to the opportunity for culture and service. The larger the opportunity, the easier the fall. The only safeguard is everlasting effort and utter sincerity."

The nursing profession offers the greatest possible opportunity for the service to which he refers—hence the chances for a fall are increased. We must, therefore, choose for our schools those least apt to yield to a weakness. "The value of a thing done," says Doctor Griggs again, "is determined largely by the attitude of the doer. The work is worth just the measure of manhood and womanhood expressed in it—never more, never less."

We must try to choose for our schools those persons who are seeking an opportunity to serve. We must, too, try to select those who have the capacity to readjust themselves constantly. Often a girl from a small high school is overwhelmed by her environment. Her home situation has been suddenly changed. Even her food is different. She does not know the hospital geography. She does not know what is expected of her and often does not know how to study. At best it will take her four or five months to come to a comfortable and reasonable

balance. Even a strong person needs supervision and bolstering to tide her over this period.

We may aim to give a well balanced program of work, sleep and recreation, but if the girl has not had the proper emotional development up until the time she comes to us, nothing we can do will make her a success in a profession so demanding as ours.

Isabel Stewart has said, "A nurse must be strong because people will lean on her. She should be trustworthy because people will confide in her. She must have a certain steadiness and self-reliance, for heavy responsibilities will sometime be put upon her. Needless to say she should have the spirit of service and she should be sincerely interested in human beings of all classes and kinds."

Until we realize the importance of selecting students who have an honest and upright foundation, we cannot hope to have our training schools composed of women capable of meeting the demands of the greatest of all professions—nursing.

## The Importance of Pediatric Nursing

From the administrative view, perhaps no point reaches a higher importance than that of pediatric nursing, Dr. James B. Cutter, director, Children's Hospital, San Francisco, emphasizes. "Certainly the nurse choosing this field for her activity must be conscious of a distinct love of her work and a peculiar adaptability," he says. "With any hope of success, it is not only necessary to develop a pediatric sense but a pediatric conscience."

"By classical authority, the following points in a nurse's education for this special service have been stressed.

"The study of child nature and child psychology, essentials of child hygiene and the principles underlying the care of both sick and well children.

"The understanding of milk modification, the realization of the importance of natural feeding and the recognition of the indications for substituting scientific artificial feeding as a therapeutic measure.

"An understanding of the leading factors bearing upon the causes and aspects of infant mortality and the conservation of child life."

## Why Boards of Trustees Should Adopt Business Policies

The trustee who confers with subordinate hospital personnel or staff physicians rather than with the superintendent may be compared to the business man who goes into his sales department and discusses that department and its operation with a subordinate salesman, ignoring entirely the general sales manager.

This often happens, says Sidney Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., because trustees fail to have confidence in their own appointee. The reason for the lack of confidence is often due to their ignorance of good hospital administration.

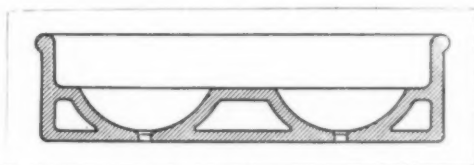
Superintendents who try to inaugurate good management often find their efforts blocked by trustees, by the staff or by others who may be affected. The trustees feel that the superintendent is a failure or the superintendent becomes dissatisfied with constant rebuffs and petty annoyance.



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## DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

# The Status of the Dietitian and What She Has Done to Advance It

By RUTH M. COOLEY

Dietitian, Jewish Hospital, St. Louis

ANNOUNCEMENT was made in the May issue of THE MODERN HOSPITAL of a competitive examination for dietitians wishing to enter government service. The duties required of the dietitian were specified as follows: to requisition and inspect all food supplies for both patient and personnel; to plan menus both normal and special; to supervise the preparation and serving of all dietaries and to perform related duties as assigned.

A casual enough announcement, but how many of those who read it realize the extent of the preparation and training required of a person hoping to perform these services satisfactorily, how many understood the patient, persistent effort necessary to carry these duties to their efficient conclusion? It is true that this concise statement may summarize the job of the dietitian in a general way, but how very different her duties may be in the various types of hospitals and how elastic that last phrase, "to perform related duties as assigned," may become.

### *Dietetics Training Comparatively New*

It has not been many years since the dietitian first made her appearance in the scheme of hospital organization. Those of us who have spent ten years or more in the work can remember when the hospitals that had a trained dietitian on their staffs could almost be counted upon the fingers. To-day the American Dietetic Association alone numbers nearly 1,500 members. In this period the standard of the dietitian has been raised so that she must hold a bachelor of science degree from a college of recognized standing, with a major in nutrition, before she is recognized. Many dietitians have gone much further and have fitted themselves for leadership in every field that the nutritionist may enter.

In addition to academic courses that fit the dietitian for her work, a course that provides for the practical application of her knowledge and gives her the opportunity to gain further insight into her institutional duties, is also necessary. At present more than a hundred courses are being given in this country, varying in length from periods of six months to a year. Of these, more than sixty meet the high standards set by the American Dietetic Association and are approved by them. The majority of students

completing such courses first enter the hospital field as assistants. This enables them to study still more deeply the methods of dietary administration prevalent in the leading institutions.

With this background and training the dietitian should no longer find it necessary to learn as she did not so long ago, by the trial and error method. Many experiences of the pioneers in the dietetic field no longer need be met by the newer members of the dietetic profession. Like any new group that seeks to make a place for itself in a large organization, dietitians of a few years ago went through many difficult periods. Much friction was caused by the usurping of duties formerly assigned to the nurse, the housekeeper and the steward. Doubtless the situation was not always tactfully dealt with, and in many cases years were required to overcome the antagonism that had been aroused.

The dietitian has proved her economic and therapeutic value to the hospital and is rapidly becoming one of the leaders in the great army of health. Her value in preventive and corrective measures for health is recognized. Not only are her services required in the hospital field but the commercial group has also recognized her value in helping it to place before the public correct facts about food. Scarcely a magazine or newspaper can now be picked up that does not contain some information of value about nutrition. The dietitian, therefore, must be able not only to direct these activities tactfully and successfully, but she must also help to teach in her institution, by precept and example as well as by definite measures of instruction, the fundamental facts about proper nutrition.

### *Cooperation With Superintendent Needed*

She is or should be responsible to the superintendent or administrator of the institution. With him she must consult about the policies to be determined for her department. Such primary facts as the arrangement and expenditure of the budget, cooperation with other departments, types of food service, complaints and criticisms that arise from time to time, wage scales, vacation allotments, the care and disposal of waste, the purchase of new and the repair of old equipment and the expansion



## Keeping Well People Well....

RESTORING the sick to health, while originally the only function of the hospital, is more and more being supplemented by the service of keeping well people well, and all over the country hospitals are taking active leadership in health educational work.

Quite properly the service of any hospital includes educational work with resident patients, out-patients, and through its community contacts—educational work to the end of preventing those abuses of right living which lead to ill balanced metab-

olism which so frequently shows itself through a diminished alkalinity of the blood and tissues due to an excess of acid products—acidosis.

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THE CHARLES H. PHILLIPS CHEMICAL CO., NEW YORK & LONDON

and development of department activities, all must be carried out according to the policies of the institution and with the sympathy and understanding of its superintendent.

Without the cooperation of the nursing school, the dietitian is helpless. For the best interests of the dietetic department, the avoidance of friction with the nursing group is greatly to be desired. Not only is the dietitian responsible for the training in the dietetic classroom and in the diet kitchen of the student nurse, but she is also responsible for the nutrition of the student nurses. In turn, she must depend to a great extent in many institutions upon the training, sympathy and understanding of all the members of this great nursing school group. Food that is properly purchased and prepared may often be spoiled by improper handling by nurses who are not well versed in the fundamentals of feeding, and who have little interest in the work the dietitian is striving to accomplish. Central service units in many cases help to overcome this handicap, but a still greater problem may be the failure of the nurse to obtain the cooperation of the patient in regard to his food. The patient's attitude toward the hospital and his reaction to its various functions are obtained in large part from the nurse. Tact and patience and earnest endeavor to work together will solve many difficulties in the relationship between the dietary department and the nursing school, a relationship that is of inestimable value to the institution itself. This policy, of course, should be carried out in relation to every other department in the institution. It should take into consideration the housekeeping, the bookkeeping, the engineering departments, the laundry and the storeroom, with which many contacts are to be made, as well with other less related departments in the hospital.

#### *Relation to Medical Group Important*

Of special importance is the medical and surgical group with which the dietitian in charge of the dietotherapy of the institution works in close conjunction. If the dietitian, by frequent encounters with this group, can establish the confidence of its members in her ability and in her efficiency in carrying out their orders, her work will be much more pleasant and profitable. These contacts can be made in many ways, such as by accompanying the visiting or house doctors on ward rounds, by carefully studying the charts, by meticulous care in carrying out dietetic orders and by frequent discussion of the methods to be used and the results to be obtained. Careful instruction of the patient who is on a special diet is necessary and is invariably appreciated by the doctor in charge. Many interesting methods have been worked out whereby the dietary care of the patient is extended beyond his stay in the hospital. Added duties, such as the responsibility of the teaching of nutrition in the out-patient clinic, the planning and care of kosher kitchens, the instruction of interns in institutional dietetics, infant feeding, supervision of courses for student dietitians and the planning and supervision of food for social activities in the institution, may be delegated specifically to the dietitian, depending upon the type of institution in which she is employed. All these may be included in the "related duties as assigned." Every food problem of the institution is the dietitian's to deal with to the best of her ability.

The status of the dietitian depends almost wholly upon the successful and efficient performance of her duties. Whether she conducts a department that runs smoothly as a part of a great organization, serving the patient and the personnel to the best of its ability, depends upon her

tact, her judgment, her personality and her initiative. If she gets cooperation and results in the face of rather terrific odds at times, then certainly she has justified all of the careful preparation and study that went into her training. If she accomplishes these things, she will inevitably occupy an extremely important place in the hospital group and in addition she will have opened the way for the further development and recognition of her possibilities. Expansion and progress can be attained only by constant application to the solution of the problems she now faces. The dietitian is fast overcoming her previous handicaps of insufficient training and lack of understanding and is winning for herself an enviable reputation in the hospital field.

### Teaching the Fundamentals of Dietetics to Student Nurses

Student nurses at the Massachusetts General Hospital, Boston, are being taught how to adapt special diets to home conditions, to limited budgets and to untrained minds.

According to the *Public Health Nurse*, seventeen students—at the rate of one every three weeks—are placed under the supervision of the hospital's out-patient food clinics where they are given an idea of the purpose of the clinics, observe the work of the dietitian, attend conferences with patients and assist with weighing and checking up on old cases. The assistance includes diabetic, epileptic and general case experience.

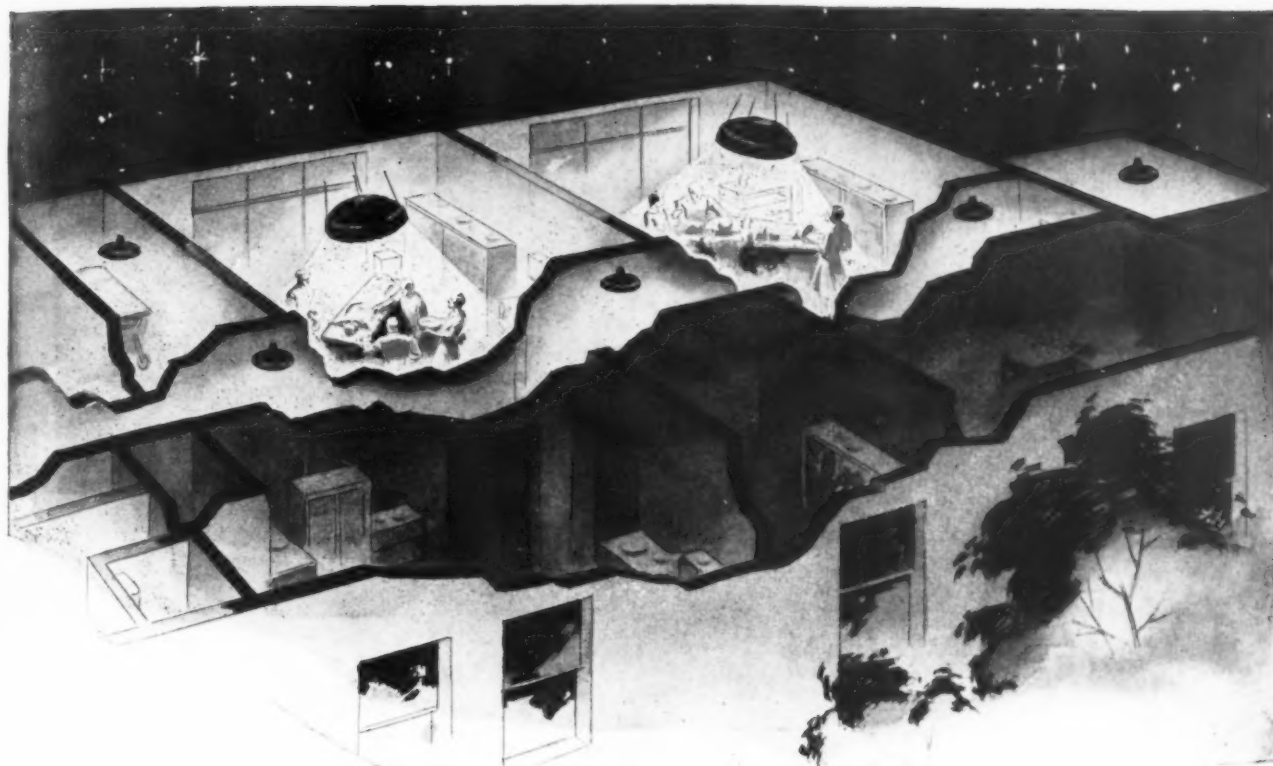
Reasons for including this experience in the training courses are to enable the student to see how important a part diet plays in the treatment of disease and in the maintenance of health, to help her to realize that many patients must be taught carefully and patiently, that diet must be directed by a physician and that medical attention and nursing care in the usual interpretation of these functions are only a small part of the service the community renders to a large part of its population limited both financially and in health intelligence.

### Knowledge That Is Fundamental to All Types of Nursing

What is modern nursing?

Whether institutional, private duty or public health nursing, the knowledge required for each varies little, an article in the *American Journal of Nursing* says. Every public health nurse must keep in touch with medical and surgical procedures. It is well to go back to the hospital occasionally for a medical or surgical clinic. The private duty nurse cannot afford to know less about health and community needs than do the families she serves. Every nurse needs a working knowledge of mental hygiene. She should be familiar with the fundamentals of social hygiene. She should be familiar with prenatal care, and with child care. She should know how to secure hospitalization for any patient requiring care, rich or poor, pay or no pay. She should know about local and state institutions, about the make-up of the health department and its divisions.

Since no difference exists in the fundamental training of nurses, the article points out, no difference should exist in the continued studies for nurses except in purely technical procedures.



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# The Part the Health Clinic Plays in Modern Medicine

By JOHN V. LAWRENCE, M.D.

Assistant Professor of Medicine, Washington University, Medical Director, Washington University Dispensary, St. Louis

THE initiation of a strict health clinic in a region where the conception is new both to physicians and clients must usually take the course of developing from a clinic whose patients are not in good health and who seek health examinations because of a conviction that they are not in perfect physical condition. Also the training and interests of the physicians are usually such that they are unable cleverly to carry out preventive measures.

The report of a year's practical research under the direction of the Committee on Dispensary Development of New York on the "Scope and Cost of Health Examinations" has this to say about the health clinic: "The real difficulty in conducting a health clinic lies in finding healthy persons to attend it. In this study, the 872 supposedly healthy persons who were observed revealed, on examinations, only twenty who were not in need of health direction. Practically all of the socially dependent group stand in need of medical treatment."

### *Public Confused by Health Problems*

It should be kept in mind that organized endeavor in clinic development was not and is not initiated by the medical profession. The process of groping about by the layman for the solution of his health problems is greatly impeded by the lack of medical leadership, but it is not stopped. The public is becoming more and more confused about the solution of its health problems. The increasing complexity and cost of the improved methods of the special branches of medicine only augment the confusion. There is no intelligent direction given—unless certain local experiments of publicity now being tried are successful—as to where the best medical attention can be found, and often when it is found it is beyond the means of a large class of patients.

Medical men are prone to forget that the layman cannot distinguish between the function of an x-ray and an Abrams machine. He approaches sickness with his available money, hoping that he will gamble luckily into the right channel. According to a recent statement by an eminent physician, "The public is on the hunt for the medical profession and is evidently going to find it. Is it going to find it lacking?"

Commercial industry has insisted for several years that

a means be found for solving the health problems of employees with efficiency and economy comparable to all other methods in business. Huge portions of society are now cared for medically in an organized fashion by the time clock efficiency methods of great industries. These industries maintain medical and surgical staffs in their own plants as a necessary overhead expense for the efficiency of their plants. This is not because it is a part of their business, but because there is no medical group to whom they may turn for this commodity. If they can buy a better item from a firm that has developed excellence in the production of this item they usually stop their own production and get it elsewhere, especially when it pertains to overhead. Already big industry has its ear to the ground for the possibility of obtaining health items from clinics that can furnish them in abundance. Organized groups outside the factory are getting as much of this work as they can be depended upon to furnish. Cornell Clinic is being approached on this subject. Certain Chicago concerns maintain relationship with hospitals through the medical services of the hospitals and use beds from the lowest to the highest rates.

### *Industries Provide Medical Care*

Statistics from "Medical Care of Industrial Workers" published in 1926 by the National Industrial Conference Board of New York show that in eight states "more than two and a half million workers in 4,659 companies employing fifty or more persons were receiving medical care. Fully equipped hospitals are maintained by 10.9 per cent of these companies."<sup>2</sup>

The health demands of the public at large are not met by industrial supervision, but similar protection from fraud and quackery is sought. These demands, which are becoming more and more insistent, are not met by the medical profession due to its code of ethics. In fact the medical profession is so intangible to the public at large that questions concerning medical guidance are directed to lay organizations such as social welfare societies, life insurance companies and public health departments of cities and counties.

It is not intimated that the clinic should bid for any mass of health work, but an institution that is training



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physicians who must do this work should be alive to the importance of maintaining a model clinic subdivision for instruction and inspiration in preventive measures and in health examinations.

Although the undertaking of a health clinic may seem to require little except elementary medical training, this is not the case. Actually the conduct of a health clinic should be in the hands of one with unusual breadth of training in medicine, genetics and psychology and with a talent for coordination. It involves a knowledge of the subject of "positive" health which cannot as yet be found in textbooks. A profound interest and knowledge of heredity and habits in relation to health and disease is fundamental. It requires a point of view, training and enthusiasm different from that of the man who searches for pathology in the usual medical clinic.

### *New Field for Study Opened*

The problems of study of the so-called normal individual open a new opportunity and field for study of the individual in relation to predicted pathology arrived at from anthropometric indexes of form and interpretation of personality and behavior factors. It is not sufficient reason to incorporate the examination of the normal in a scientific institution merely to glean insidious evidences of focal infection of the teeth, tonsils, sinuses, gall-bladder, bowel, fissures, or prostate, or to correct malnutrition, obesity and constipation, or to give advice for adjustment to an evidently harassed, worried and depressed individual. Such considerations are important and will make the health clinic practically possible, but the greatest value to the progress of medical science will be the opening of a new field of interest and knowledge of the correlation of the attributes of man with adjustment to his environment. The prediction of diseased states is nearly an unexplored study and pioneers in the field may not be easy to find.

Relative to the study of the well and sick client in a scientific institution, a clinic dealing with a more serious study of anthropometric measurements and factors of heredity should be mentioned. Such a clinic, which may be termed a constitutional or behavior clinic, involves the biometric analysis of data and belongs only to a modern and well established out-patient department. The cooperation of a trained statistician for hospital case study is conceded to be an important point long overlooked by clinics and hospitals.

It is futile to assume that physicians not trained in biometry can scientifically analyze data in an intelligent statistical manner except in a very elementary fashion. The biologists and life insurance companies are far in advance of the clinician in the statistical analysis of data. Their data are collected at great effort and are primarily for analysis. The data from a clinic are collected automatically almost as a by-product of the routine, and are valuable because they pertain to humans.

The most pretentious constitutional clinics in this country are probably at Johns Hopkins Hospital, Baltimore, and at the new Columbia-Presbyterian Medical Center, New York City.

Already the influence of the health clinic is reaching the rural communities of the Atlantic and the Pacific seaboard states, but not so actively is it reaching those of the Middle Western states. The interest in this work and the desire to further it on the part of the rural and urban physicians of North Carolina are surprisingly active. Plans are under way to keep a peripatetic instructor on full time to disseminate to physicians in various parts

of the state information about the detection and prevention of disease. There exists in the training of physicians a recognized deficiency to detect the forerunners of disease, to diagnose its incipient stages and to consider the patient before he becomes bedfast.

The health clinic, strictly speaking, is not to be confused with a health center, "an organization that provides, promotes and coordinates needed medical service and related social service for a specific district," (Dr. Michael M. Davis) or with a diagnostic clinic that exists for the diagnosis of pathological conditions. The health clinic exists, to quote from Dr. C. Ward Crampton, "to give a thorough health survey with appropriate instructions on diet, exercise and life management, to prevent the occurrence of unnecessary disease, to discover and cure it if present and to recommend a manner of living that will lengthen the years and fill them with health, happiness and efficiency."<sup>3</sup>

The type of service rendered in a health clinic is best adapted to clinic organization where adequate consultation and laboratory service may be obtained at the minimum of cost consistent with accuracy. Of the modern clinic endeavors that are bringing adequate service to the patient of moderate means, it may be freely endorsed by the private practitioner. The health clinic is not only vital to public health, which is the justification for any clinic, but it guides many clients into the hands of private physicians to carry out indicated procedures that would not be discovered by other means. Health clinic service and records enable the private practitioner to proceed with a patient in the near or distant future with the adequate information that is necessary for the modern practice of medicine.

### *First Noted Health Clinic in Boston*

The first noted health clinic utilizing specialists for the purpose of group diagnosis was organized by Dr. Lesley H. Spooner at the Boston Dispensary, Boston, in the Fall of 1919 and it is still active as one of the outstanding health clinics. At present it is in session three evenings a week and offers for wage earners and persons of small means, "who are troubled about their health or who want to prevent trouble," the opportunity for a thorough physical examination. The routine involves the services of an internist, nose, throat and eye specialists, laboratory tests and, if indicated, consultation from the genito-urinary, dermatological and gynecological departments, all for the one fee of \$7.50 which is about the cost of the service.

Well organized health clinics are to be found at the New York Post-Graduate Hospital, New York City, under Crampton's guidance, at the Boston Dispensary, at the New York Polyclinic Hospital, New York City, under Dillon's guidance and at Cornell Clinic. These clinics charge for services from \$7.50 to \$10 and refer patients to other clinics or private physicians for treatment. Doctor Crampton's enthusiasm and vision do much to popularize this type of clinic. In his words, "It is the most worth while type of medicine," and from the viewpoint of research, its value can hardly be estimated. It will serve as a correlating mechanism between medical history, *status praesens*, preclinical signs, hereditary factors and anthropometric indexes, which has never before been attempted. It can be readily inferred that the training, vision and enthusiasm of the chief of such a clinic must be unique.

### *References*

- <sup>1</sup> Nation's Health, June, 1928, Vol. V, No. 6.
- <sup>2</sup> Ferguson, Health in Industry, Journal of the American Medical Association, Sept. 22, 1928, Vol. 91, No. 12.
- <sup>3</sup> Crampton, C. Ward, M.D., The Health Examination and Its Distinctive Features, Medical Journal and Record, Oct., 1925.

  
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## How Des Moines Health Center Serves the Community\*

**D**URING 1928 the Des Moines Health Center, Des Moines, Iowa, played a substantial part in the health affairs of the community and held a satisfactory position among the members of the Des Moines Public Welfare Bureau family. Interest in its work is not only local, but it also extends to other cities throughout the state and even into neighboring states. Last year many outside visitors called personally to study the system and many more wrote for information. Des Moines citizens were encouraged to visit the health center to get first-hand information and the staff gave public talks to various organizations to help bring about a better understanding and appreciation of the work.

During last year, 2,929 patients were referred to the health clinic by other agencies, the family social service leading with 389, the public schools coming second with 349, the juvenile court third with 341 and the county hospital fourth with 271. During the year 1,256 reports of findings were sent out to the various agencies, the family social service leading with 383, the juvenile court coming second with 312 and the city health department third with 281.

Patient visits increased in the following clinics: general physical, medical, surgery, head surgery, psychology, infant feeding, obstetrics and laboratory. The accompanying table gives the attendance in the various clinics. Twenty-eight Des Moines physicians contributed 1,154 hours of service to these clinics during the year.

It is part of the day's work at the health center to interview each new patient. In these contacts many problems are brought to light. One of the biggest problems is that of nonresidence. During 1928, there were 422 nonresident patients at the health center. Of this number 211 were from other parts of the state and 211 came from other states. For these patients 782 contacts with the different clinics were made.

The disposition of these cases by the social service department has varied according to the individual case. If the head of the family had a steady job, and, with the exception of a little medical care, the family looked as if it could get along without assistance, the department took care of the patient, but always tried to collect the small fees. If, on the other hand, the family conditions seemed to indicate that the family would soon be applying to some other agency for help, the family social service was asked to investigate the home. Others were referred directly to the county overseer of the poor. Again, if the patient had a chronic ailment, for which the doctors thought he should be treated in the hospital, the social worker urged the patient to return to the county from which he came and get papers filled out for the University of Iowa Hospital at Iowa City. Others were referred to private physicians and in a few instances some were referred to private hospitals. However, all emergencies were taken care of at the county hospital.

Each patient who comes to the health center is checked up within a week's time and if he has an appointment to return to a certain clinic and does not keep it, he is sent

a "follow-up letter," in which he is told that the health center is anxious to know how he is getting along, and he is urged to report to the clinic. The cooperation of the patients in this work has always been remarkably good. This year the social service department inaugurated a system of follow-up letters with patients who have a venereal disease. They use a series of three letters, sent out at stated intervals, urging the patient to return to the center and then the center in turn refers him to the venereal disease dispensary for treatment. If the health center receives no word from the patient after the third letter he is referred to the city health department for follow-up.

### ATTENDANCE AT THE VARIOUS CLINICS OF THE DES MOINES HEALTH CENTER

General Physical .....	1,678
Dental .....	2,159
Medical .....	1,269
Head Surgery .....	2,295
Surgery .....	492
Orthopedics .....	1,349
Cardiac .....	300
Tuberculosis .....	402
Gynecology .....	213
Urology .....	156
Dermatology .....	257
Neuro-Psychiatry .....	263
Psychology .....	525
Infant Feeding .....	292
Pre-School .....	124
General Pediatrics .....	373
Obstetrics .....	603
Physiotherapy Treatments .....	1,227
Laboratory .....	2,383
<hr/>	
Total Examinations .....	16,360
Old patients .....	9,859
New patients .....	2,353
Male .....	5,793
Female .....	6,419
<hr/>	
Total patients .....	12,212

It was only necessary for the center to refer two patients to the city health department last year.

The social service blanks used at the health center are now identical with those of the social service department of the Broadlawns General Hospital, Des Moines. Social findings gathered in the health center and in the hospital are being used interchangeably. The two departments work with a great number of the same patients because the patients who have been in the hospital are referred to the health center for follow-up work and on the other hand, the patients who are examined in the health center are often referred to the hospital for care. The social service department serves as a connecting link between the patient in the health center and the cooperating agencies, always aiming to obtain proper care for the patient.

\*Abstracted from the ninth annual report of the Des Moines, Iowa, Health Center.

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The Board of Trustees and the writer wish to convey their heartiest thanks for this splendid outcome.

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# The Science of Spending and Saving in the Hospital\*

By SISTER M. JULIA

John B. Murphy Memorial Hospital, Chicago

**E**CONOMICS is the science of wealth getting, a definition that covers all phases of economics. More attention is being given to this subject now than ever before, not only by the federal government but by large and small industrial corporations where it is beginning to become as important as production and sales. Large amalgamations of banking institutions have been effected by the leading financiers of the country in the past year with economy of operation undoubtedly influencing the executives in their decision to combine.

If this is the situation in other lines then why should it not be effective in hospitals? Even more so should we have economy in hospitals, for here economy surely walks hand in hand with charity. The more economically the hospital is managed the more favorably is it bound to affect the patient. Our duty to the patient is not only to relieve his physical illnesses but also to reduce the cost of his being sick.

We must never forget that the hospital is for the patient. On one occasion when Dr. John B. Murphy was holding one of his remarkable surgical clinics in Mercy Hospital, Chicago, he turned to a young intern and asked, "Doctor, who is the most important person in the hospital?" Hesitating a moment the intern answered, "You are, doctor." "Oh no," said Doctor Murphy pointing to the patient on the operating table, "there is the most important person—your patient."

Organization for economical purposes is essential. Good organization brings all departments into systematic relationship. The responsibility of managing a hospital is placed on every person connected with the hospital from the superintendent to the maid on the floor. Head nurses need not think that the responsibility of housekeeping is taken off their shoulders when a housekeeper is employed. The new maid should be shown the most economical way to use a brush, the new house man should be taught how to wax the floors and how to use soap economically but effectively. Seventy-five per cent of our nurses do not think that it is their duty to know anything about housekeeping. But if they do not, their departments show it.

One of the first principles of scientific management is to systematize each piece of routine work so that it may

be done in the shortest time with the least expenditure of energy. If systematic work saves time, the hospital is the first place in which to begin the campaign for scientific management. Efficiency means producing the best results without any waste of time, labor and materials.

The John B. Murphy Memorial Hospital, Chicago, has been in operation for about seven years. In July, 1928, the community bought it from a group of doctors. The problems we faced at that time were probably more complex than those that we should have met in opening a new hospital. Our school for nurses was affiliated recently with the Illinois Training School for Nurses. Every nurse, graduate and student is willing and ready to cooperate with the Sisters in every way in the care of the sick and injured. Through the cooperation and careful management of the superintendent of the hospital, the superintendent of nurses and the Sisters in charge of departments we were able to reduce our pay roll about \$2,500 a month during the last ten months.

It is an economy to employ capable persons at a fair rate of remuneration. In selecting the hospital's personnel every effort should be made to secure those who are willing to take advice, who are intelligent and teachable. Few persons think of things in daily use in their relation to dollars and cents. Saving is a state of mind and every person must have some reason that gives him an impulse to save. The hospital management may have a well worked out system of buying that would save money but for the fact that the institution is wasteful in the use of materials. The idea of making supplies last longer and go further, and general carefulness in the use of hospital property should be impressed upon the personnel. When this has been accomplished a great deal has been done toward solving the high cost of hospital operation. However, hospital workers must keep always in mind that the character of hospital work requires service, not saving. Saving is not economy if it fails to attain its ultimate purpose.

A complete requisition system is in use throughout the John B. Murphy Memorial Hospital. No doubt to some of our personnel it seems unnecessary to write and present an order for small articles. Soon, however, it becomes an understood thing that nothing is given without a requisition. The workers appreciate more the things they have

\*Read at the annual meeting of the Catholic Hospital Association, Chicago, May 6-10.

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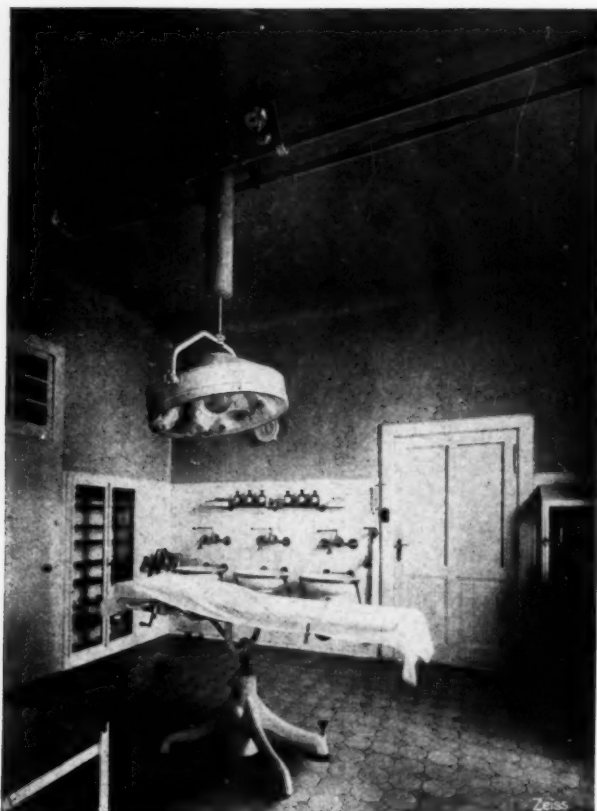


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to request, and the little touch of formality accompanying a requisition is a good thing. It is also noticed that heads of departments and others in making their requests more frequently present the matter from the standpoint of effecting an economy than they did formerly.

Upon the buyer falls the task of holding down expenses which is the first step in the reduction of hospital costs. A good buyer is one who cannot be swayed by unscrupulous salesmen. I know one salesman who raises the price on rice one and one-half cents when he calls on a certain institution, because he says the buyer will insist on a lower price than he quotes first. Another salesman remarked that he ceased calling up a Sister for orders because he could not make any profit selling to her. I was curious to know what she did. I inquired and was told that she simply insists on knowing the prices of fruit and vegetables when she places her order. She is familiar with prices and goods and does not place the order with one firm if she can do better elsewhere.

### See Every Salesman

The reputable salesman has a straightforward story of quality and dependability, he does not jeopardize the reputation of his house by resorting to trickery and he proves that his house is the most economical with which to deal. It is well for the buyer to see each salesman if time permits. He may have something new to show that will be an advantage to the hospital. The buyer should have the privilege of making his purchases wherever he can get the best quality and the lowest prices. To buy because the hospital has bought from a certain firm for forty years is not a sound policy.

Four rules for buying are:

1. Know what you have. To do this you must have a central storeroom and make use of inventories and requisitions.
2. Know what you need. The buyer should know this better than any salesman. Do not be a routine buyer. Do not buy just because you see a bargain. Investigate first.
3. Know what you paid. This is most important. Did the previous purchase render the service you expected?
4. Take your discounts. In other words, pay your bills promptly, if possible. The amount saved by taking the discounts can be used to great advantage.

If the purchasing of supplies is concentrated in the central office rather than with department heads, the department heads should be consulted and given an opportunity to make their requests and to give their opinion of the goods previously purchased. It is true that the Sisters in charge of departments have enough to do to supervise the work of their departments efficiently. Anyone can check supplies, but anyone cannot be a supervisor of an operating room.

This method of ordering goods is followed at the John B. Murphy Memorial Hospital: Every Saturday the Sisters in charge of departments send to the office of the buyer a requisition for the supplies needed. If the supplies are in stock they are delivered promptly on Monday morning. If not, they are purchased Monday. All new goods are accepted in the receiving room, signed for and a receiving slip made out and attached to the invoice which is sent to the office to be checked with the statement on the first of the month.

Good canners now pack and grade fruits and vegetables for size as well as for quality. Peas, string beans and asparagus come in numerous sizes and the utility of each size should have careful consideration. Table fruits come in three grades, fancy, choice and standard, and there are several sizes in each grade.

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DEACONESS HOSPITAL  
Billings, Mont.

It's clean! Here is efficiency—smooth, clear floors and shining walls. Cleanliness is a breeder of confidence. It's much easier to believe in a clean hospital than a dirty one and oh! how spic and span things can be kept with

# TILEOLEUM

## THE PERFECT CLEANSER

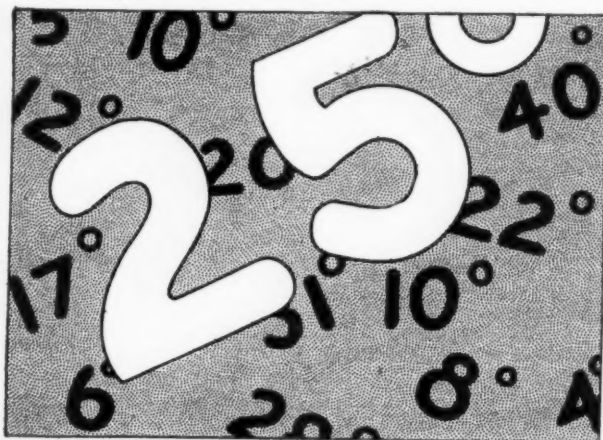
It's not an expensive way—this Tileoleum method. In fact it is much cheaper in the end. It takes so little to do a lot of cleaning. If you could see the dirt come out of a supposedly clean tile, marble or terrazzo floor—after Tileoleum gets on the job you'd

know why so many are turning to this Perfect Cleanser.

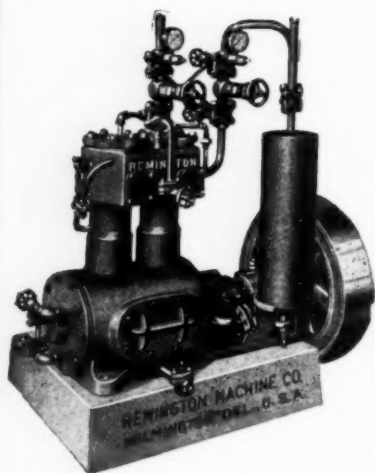
A Midland Service Representative will gladly demonstrate in your hospital. No obligation whatever. Just write us and say, "We'd like to see Tileoleum at work on our floors."

**MIDLAND CHEMICAL LABORATORIES, Inc.**

DUBUQUE, IOWA, U. S. A.



## WHATEVER TEMPERATURE YOU REQUIRE



Our New Series C Compressor—designed to make a trouble-proof small plant. No valve in piston or in head. Ring plate valves, high-speed, bushed all over, safety head.

**T**HE advantages of having your own refrigerating plant are easy to see. You can fix the degree of cold to suit your needs; you can maintain a constant even temperature; you can have automatic control; you can be independent of delivery inconveniences and storage; above all you can *economize* on your refrigeration. Drop us a line (on your letterhead) outlining your conditions and we will offer recommendations.

**REMINGTON MACHINE CO.**

419 E. FRONT ST., WILMINGTON, DELAWARE, U. S. A.

*Since 1872 the Remington Machine Co. has pioneered in the manufacture of machinery for making ice and for general cooling purposes. The line includes milk coolers, water coolers and ice plant equipment, portable and heavier types, adaptable to any power.*

**Remington**  
of WILMINGTON  
EST. 1872

The buyer and the seller often cling too closely to a list of items purchased the year before. The buyer, being short of time, sees no necessity for examining samples of other products or the same product in another form that might be satisfactorily substituted either in part or in whole, and the salesman, not wanting to intrude on the buyer's time or to open expensive samples, does not do the best possible job of informing the buyer of new products.

Have you ever compared the prices of the canner and those of the wholesale dealer? The price on mill goods and the price on those of the wholesale dry goods dealers? The middleman's profit is eliminated. Each year we request two or three reliable firms to submit prices on canned goods that we shall use during the year. It is interesting to compare these quotations. Care must be taken that goods of equal value are compared.

It is a good practice never to purchase goods, in considerable quantity, at least, without asking for bids. The buyer must be careful not to buy large quantities unless a saving is made. Money will earn interest for the hospital as quickly as for the firm that overstocks the hospital storeroom. We contract for gauze for three months. On the twentieth of each month we receive a shipment. At the end of three months we take all that is not used on our contract but we do not order again until this supply is exhausted. The Sister in charge of the surgical department supervises the making of dressings used in the hospital. The amount of gauze used the last ten months is about half the amount used during the same months of the previous year.

### *Drugs Should Be Bought Wholesale*

The drug room is another important department. Drugs should be bought wholesale and bids should be submitted. Stocking the drug room with cheap drugs is not an economy. If you can please 75 per cent of the staff members with drug supplies your drug room is not overstocked. Our inventories are not fictitious. A charge sheet is sent to the bookkeeper daily. We have a profit on drugs and our patients are not overcharged.

We have installed modern kitchen equipment and refrigerators. We have a refrigerator for meat, one for fruit and vegetables and one for dairy products. The refrigerator system assures us absolute control of food temperature continuously and economically. This new equipment cost about \$5,000 but it was money well spent. For instance, since the installation of the refrigerators, meat can be purchased in halves and quarters at a saving of several cents per pound. One of our cooks is also a butcher. He makes the requisition for meat, receives it, cuts it, cooks it and serves it. No meat is wasted.

Bread should be bought in long loaves. There are more slices and less waste. The bread cutter saves five to six slices on every loaf that is cut. A six-pound loaf of bread can be cut by an electric machine in twenty seconds. It requires three minutes to do it by hand. Forty pounds of butter cut in forty-eight pieces to the pound can be done in twenty-five minutes by machine.

A hundred pieces of flat silver can be cleaned in twenty-five minutes by an electric silver cleaning machine. An electric meat chopper chops all kinds of meat, fruits, vegetables and nuts without waste and saves much time and labor. An electric ice cream freezer reduces the cost of ice cream to about half. No dessert is so desirable as ice cream in a hospital. On the other hand, some equipment may be an increased cost. A potato peeler may cut away too much potato if not turned off at the proper time.

The waste of food supplies in a hospital can be remedied by the central control of supplies. A central serving

## DO YOU ONLY COMPLY WITH THE LAW OR REALLY PROTECT the Patients, Nurses, Doctors and Internes?

Recent Hospital catastrophies have proved that even if the patients are not bedridden it is next to impossible for them to escape by ordinary fire escapes, ladders or stairways and with helpless patients, just imagine yourself carrying them one by one down the stairs or ordinary escapes.

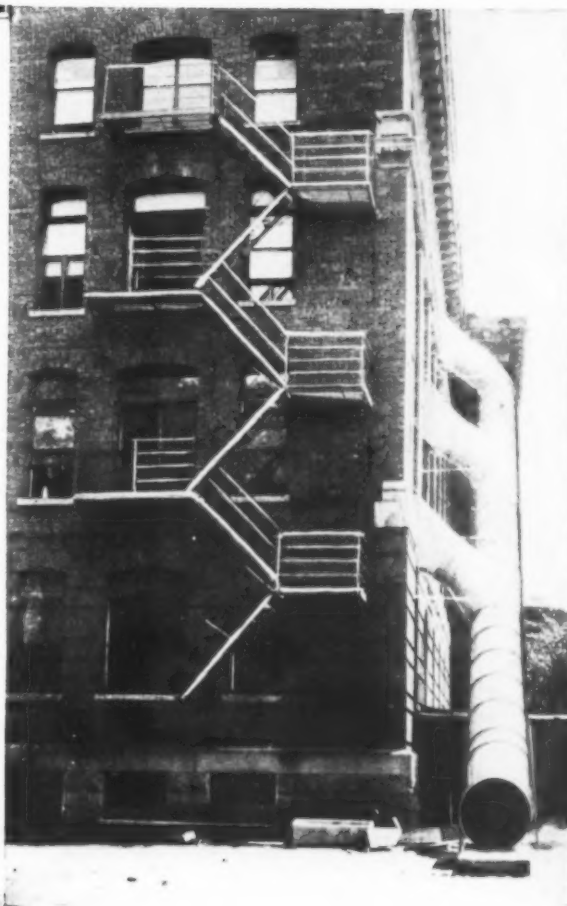
*The Montreal General Hospital as pictured at right had common escapes with wide exits and large platforms, but installed five Potter Tubular Slides by which bedridden patients may be slid on their own mattresses, wrapped in their blankets to safety, regardless of gases, smoke or fire.*

### Real Safety Protection

*Write for Prices and Complete Details.*

**POTTER MANUFACTURING CORP.**  
1866 Conway Building, Chicago, Illinois

*The Only Fire Escape With a Service Record Approved by  
the Underwriters' Laboratories*



*New York State Psychiatric Institute, 168th St. and Riverside Dr., New York; One of Many Hospitals Equipped With*



SULLIVAN W. JONES, State Architect

## BROWNE WINDOWS

### PERFECT VENTILATION

Elimination of Drafts; Maximum Light and Vision; Absolute Weather Protection; Noiseproof when closed; Safety and Economy in Cleaning exterior of glass from inside; Simple, Easy Operation; Continuous and Lasting Service; No Depreciation; Saving on Fuel, Heating Equipment and Maintenance.

*A special type requiring no restraint bars was used in illustrated building; other types to suit every hospital need.*

Samples displayed with Architects' Samples Corp., New York; Architects' Exhibit Corp., Boston; Architects' Exhibit, Inc., Cleveland; and illustrated in Sweet's Architectural Catalogue.

**Richey, Browne & Donald, Inc.**

2101 Flushing Ave., Maspeth,  
New York City

# THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three-Compartment Hot Water Plate. Tea Set is seamless with inside rounded bottom and reinforced band around top. Covered Soup Cup with Silver Soldered Handles. Sherbet Dish, Gravy Boat, Individual Napkin Ring and Tray Marker, Bud Vase, Salt and Pepper Shakers and Superior Grade Sectional Flatware.

## THORNER BROTHERS

*Importers and Manufacturers of Hospital and Surgical Supplies*

135 Fifth Avenue  
NEW YORK CITY

room is more economical and satisfactory than having food served from the pantry in each department. The trays are set up with bread, butter, salads and desserts in the central serving room. The required number of trays are sent to each pantry. We have an electrically heated cart consisting of six aluminum covered containers for vegetables, gravy and similar foods, and three flat containers for meat. About half an hour before serving the electric attachment is adjusted and the cart is heated thoroughly. The food is transferred from the range into the warm containers. The cart is accompanied by the cook and one of the pantry girls to the serving room where the electricity is turned on again. The monel metal top which ensures cleanliness and retains the heat is thrown back and acts as a table for the trays. The warm food is served quickly under the direction of the supervisor and the trays are carried promptly by the nurses to the patients. All our general trays are served in less than forty-five minutes.

Special diets for diabetics and nephritics prepared by the dietitian are sent up on the dummy to the different floors. Special nurses, returning from their meals, take their patients' trays, which are prepared in the main kitchen by the cook under the supervision of the dietitian. By this method food, time and labor are saved. No unnecessary food is sent to the serving rooms. The dietitian and the cooks have worked out the system so well that they know just how much to take to the serving pantries. The transferring of food from one container to another causes the food to lose its flavor and nutrition. We have been reimbursed long ago for the amount spent for the electric cart. The serving of trays was one of the real tasks before the advent of the cart. We have reduced the cost of food about 16% per cent during the last ten months, and at the same time we have served better food.

There is another source of saving that has been neglected. The garbage can has received some attention but the possibilities in this direction have been overlooked too often. Any hospital superintendent can spend an hour profitably inspecting the garbage cans, their surroundings, cleanliness, number, weight and contents. The profit will be increased if he becomes anxious to know where this garbage comes from, whether from the general kitchen, the dining rooms or the serving rooms.

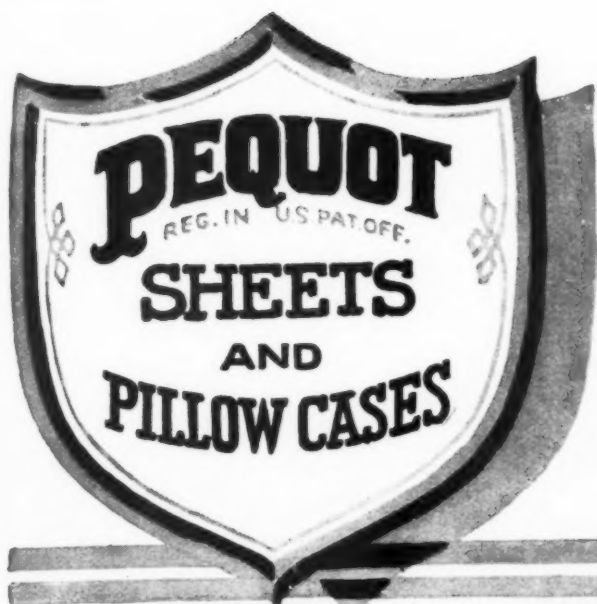
## How "Laughing Gas" Is Manufactured and Purified

Various newspapers in their descriptions of the Cleveland disaster referred to the poisonous gas that was responsible for the nearly 200 fatalities as nitrogen peroxid, nitrogen dioxid and sometimes as nitrous oxid.

As a result of these reports, a prominent manufacturer of nitrous oxid received a great number of telegrams asking whether nitrous oxid, sometimes called "laughing gas," was involved. In answer to this, an explanation of the difference between the harmless anesthetic, nitrous oxid, and the poisonous gases that caused the deaths at the Cleveland Clinic, was issued by the manufacturer and published in the *Cleveland News*.

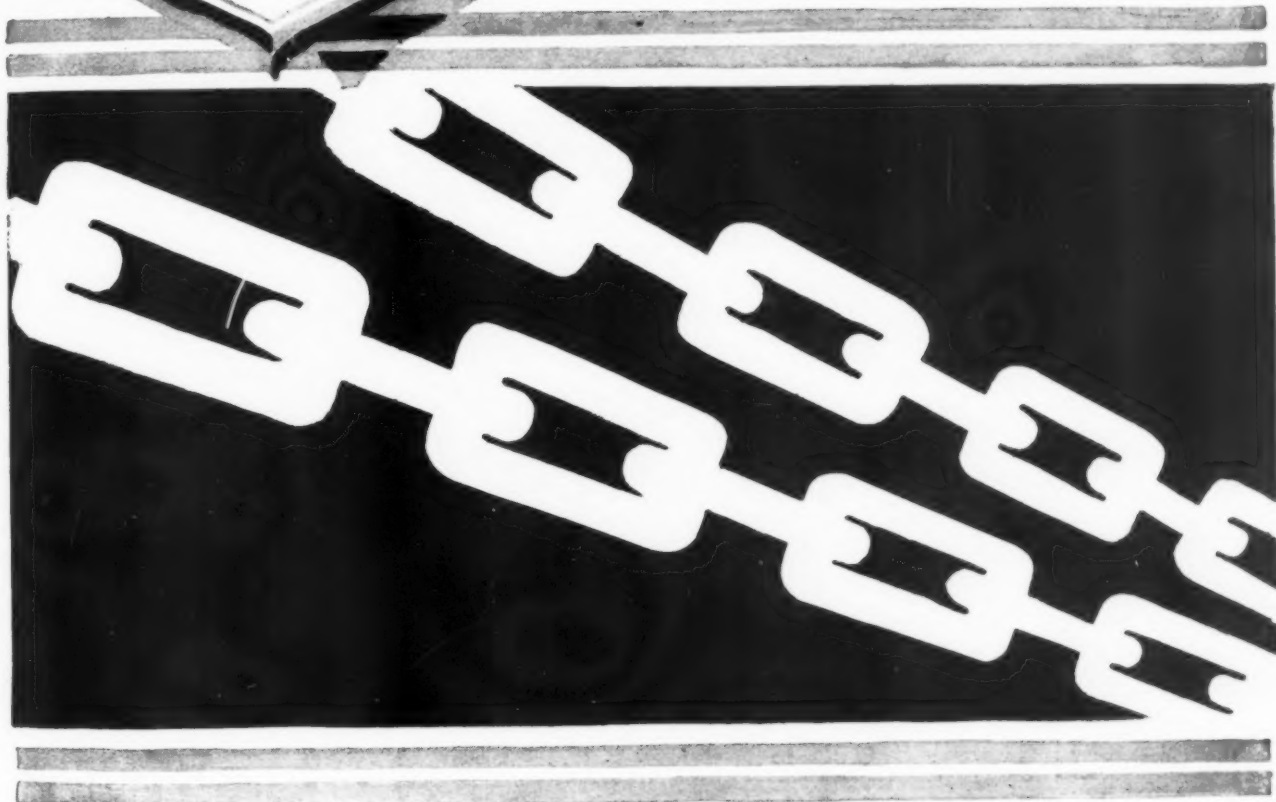
Additional information with regard to the manufacture and purification of nitrous oxid is presented here:

Nitrous oxid is manufactured in retorts by heating a very pure grade of ammonium nitrate to 412° F., at which temperature nitrous oxid and water vapor are given off. A highly purified ammonium nitrate is essential, for the presence of impurities in the raw material gives rise to



are used more by  
HOSPITALS  
than any other brand  
because of their

# STRENGTH



Pull, tug, wrinkle, strain! Every day of service—every laundering—involves powerful forces working to tear, rip, or fray your sheets. That's where Pequot STRENGTH counts! The firmly woven strength of Pequot threads means extra wear. In durability and breaking strength Pequot sheets greatly exceed even U. S. Government specifications. Send for details of Pequot name woven sheets. Naumkeag Steam Cotton Company, Salem, Mass. Parker Wilder & Co., New York, Chicago, San Francisco and Boston: Selling Agents.



1914  
1929

Indeed it is. Our fifteenth birthday. And though we're only showing part of the candles you know we haven't exactly been hiding our light under a bushel these fifteen years.

We have never held much stock in the old saw about the world beating a path to the doorway of the man who builds "better mousetraps." We figured that if our mousetraps really were better the world had a right to know it.

And the job has been good fun. There's been romance aplenty. And we've made lots of friends.

And we're going to do everything we can to extend the circle of our friends and bind the old ones closer to us through the medium of a service which we try to make, and believe is, unusual.

**Will Ross, Inc.**  
457-59 E. Water St.,  
Milwaukee, Wis.

Will  
Ross, Inc.  
1914

undesirable side reactions and consequent introduction of dangerous gaseous impurities. The temperature must be carefully controlled.

Water vapor is condensed from the evolved gases and there follows an elaborate chemical purification when traces of certain undesirable impurities are removed.

After this chemical purification it is generally considered that the gas is satisfactory for anesthesia. However, it is inevitable that considerable amounts of permanent gases will be present—as much as 6 or 8 per cent if the first heating process has been done carelessly or improperly. The preponderant impurity at this stage is nitrogen and, although it is generally regarded as a harmless diluent, there have been instances where it was believed to be very undesirable from a physiological standpoint.

In any event, anesthetic gases should be as pure as possible, and it is therefore desirable that fractional distillation be employed. In order to accomplish this, the gas is compressed and expanded through a small orifice giving rise to intense cold. This cold is carefully conserved by means of efficient counter-current heat exchangers.

Through continued compression and expansion the equipment becomes colder and colder as is evidenced by the frost that forms on all exposed parts. Finally, the temperature drops to 128° F. below zero, at which temperature nitrous oxid is a liquid at atmospheric pressure. Under these conditions of low temperature and pressure the permanent gases such as nitrogen and oxygen are not liquefied but are gaseous and can be easily removed. The liquid nitrous oxid at this point is about 99.7 per cent pure.

The purified liquid nitrous oxid is then led off and expanded into storage tanks from which it is recompressed into cylinders that have been cleaned and sterilized.

### A New Odor Eliminator

An exhibit of unusual interest at the International Hospital Congress at Atlantic City, N. J., this year is a new electrical appliance that instantly removes all bedpan and toilet bowl odors.

In its portable form, the device is simply hooked on the bedpan and begins to operate as soon as the electric cur-



rent is switched on. No chemicals or deodorant of any kind are used. When in operation, it draws a gentle current of air through a filter, the process instantly and completely removing every trace of odors. Another model

# CONCENTRATED LIVER EXTRACT

*Accepted by The Council on Pharmacy and Chemistry  
of The American Medical Association*

## Newest product of the Armour Laboratory

Concentrated Liver Extract, a new organotherapeutic preparation, has been added to the products of the Armour Laboratory. Its principal use is in those cases of pernicious anemia where the patient is unable to take solid food. As the condition improves, it may be employed as a pleasant alternative in the otherwise monotonous solid liver diet.

This preparation is made by the process originated by the late Dr. K. K. Koessler and his co-workers, Drs. M. T. Hanke and S. Maurer, in the laboratory of the Otho S. A. Sprague Memorial Institute at the University of Chicago.

Concentrated Liver Extract contains in soluble and stable form the principles from fresh liver active in blood regeneration. Each 16-ounce bottle contains, in liquid form, the soluble extractives of 8 lbs. of fresh liver. The average dose is one tablespoonful three times a day. It is best administered in milk or orange juice.

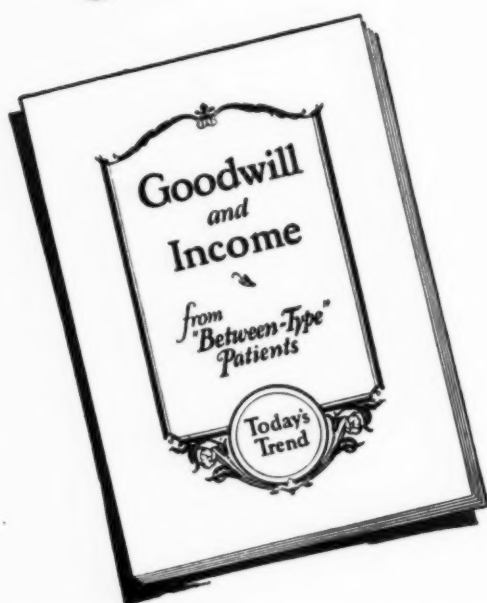
Again we earn fairly the reputation for being "Head-quarters for therapeutic materials of animal origin."

**ARMOUR AND COMPANY**

Chicago



# Here's A Book YOU Ought To Read



EVERY hospital executive interested in developing his institution during 1929 should read this booklet, which deals with the problems of the "Between Type" patient, and how they may be solved to the advantage of hospital and community alike. It is not a catalog; it reveals a new source of good will and income easily accessible for practically any hospital, large or small.

This booklet, prepared by the Professional Service Department of this company, will be sent free on request to hospital executives. Write for your copy today.

HENRY WEIS MFG. CO., INC., Elkhart, Ind.

## WEISTEEL

**SHOWER STALLS-COMPARTMENTS-CUBICLES**

is also available for permanent installation on any toilet bowl.

St. Luke's Hospital, Chicago, and other leading hospitals and sanatoriums of the country, have adopted this ingenious device and place great value on its perfect reliability in removing one of the most disagreeable factors connected with the nursing profession.

### Protecting Silverware by Careful Cleaning and Polishing Methods

Silverware is too costly to neglect or abuse. Yet it is neglected if it is not cleaned regularly and it is abused if it is cleaned with a poor polish or by a poor method, according to an article in *Hotel and Travel News*.

Machines that have been put on the market for the purpose of cleaning silver when properly handled perform an efficient job with little or no detriment to the article itself. But such a machine cannot be operated by anyone who is ignorant of the intrinsic value of the merchandise or who is inappreciative of the attractive appearance of a well cleaned piece of silver.

Most of the trouble that is encountered in the mechanical cleaning process can be laid to three reasons: first, an inexperienced operator; second, using the machine for such articles as water pitcher frames, mustard frames and coffee cup holders which because of their construction do not lend themselves to any method other than the hand process; third, the necessity, regardless of contrary arguments by promoters, for cleaning the contents of the machine occasionally.

Another matter of constant concern is the necessity for making sure that all knives are thoroughly dried and never placed in a damp location. Blades are constructed of steel. Steel rusts when damp. All silver plated knives—even those carrying a heavy deposit of pure silver—will through constant use and sharpening wear away. Then the uncovered edge of the steel will rust if subjected to any dampness. The stainless steel blade which has come on the market in recent times contains an element that is as nearly rustproof as composition with steel can be made. As a precaution, however, it will be well to insist that these knives be thoroughly cleaned and dried before they are placed away. In this connection the term "stainless" should not be taken too literally. Certain foods contain acid ingredients that will stain any blade. The term "stain preventive" is more accurate and less likely to convey an erroneous impression.

### Adding New Life to Surgical Tools by Plating With Chromium

The process of applying chromium in plate form to other metals was developed only a few years ago to the point where it could be used with commercial success. Manufacturers of numerous, varied products quickly adopted it to give added beauty and durability to their products. Little was it realized at this time, however, that chromium plating would come to mean so much to the hospital and its surgeons in preserving surgical instruments in proper condition.

Typical products, in addition to surgical instruments, that are chromium plated to-day are plumbing fixtures, bathroom and kitchen fittings, printing rolls, stainless steel, hinges, door knobs, golf club heads, automobile head

## RESEARCH PROVES ANTI-RACHITIC PROPERTIES OF COCOMALT



*Radiograph of the tibia of a rachitic albino rat showing the wide zone of decalcification, the so-called rachitic metaphysis. From this point on, a fraction of a gram of COCOMALT was fed daily in addition to the basal rickets-producing diet (Ration 2965).*



*The same bone eight days later showing the beginning of the curative process. Note the deposition of calcium in the provisional zone of calcification.*



*This radiograph was taken at the termination of the experiment in the ninth week. Recalcification is complete and the animal is pronounced cured.*

After many months of research by prominent authorities in the field of nutritional chemistry we are gratified to prove that Cocomalt, in addition to its many other attributes, contains vitamin D, the anti-rachitic vitamin which promotes normal ossification in bones and teeth. Without this vitamin or ultraviolet light, calcium and phosphorus deposition cannot occur, with the result that rickets develop. In addition, laboratory tests show that Cocomalt contains Vitamins A and B. Comparative tests also revealed the fact that Cocomalt contains, gram for gram, about the same amount of the vitamin B complex as raw whole wheat.

Cocomalt is not a medicine. It is a nourishing, easily digestible, natural food with a delicious chocolate flavor. Physicians who experience difficulty in persuading patients to drink milk will find Cocomalt palatable and invaluable.

Cocomalt increases the caloric value of milk 70%. For that reason alone it is useful in diets of convalescents when the physician wishes to build up body weight as rapidly as possible. Served with milk, Cocomalt makes an excellent supplement to the average dietary, adding proteins of the highest biological quality, mineral elements (especially calcium and phosphorus) in the proper proportions and vitamins A, B (complex) and D.

Cocomalt is recommended for convalescents, growing children and adults and can be fed to advantage wherever milk diets are indicated.

# Cocomalt

© R. B. DAVIS CO. '29

R. B. DAVIS COMPANY • HOBOKEN, N. J.



**SIGNALING  
SYSTEMS  
FOR  
HOSPITALS**

**NURSES' CALL**

**DOCTORS'  
PAGING**

**AUTH ELECTRICAL SPECIALTY CO.**  
422 E. 53rd Street New York City

*Write for New Catalogs of Telephones,  
Hospital Systems and Annunciators.*

**A RELIABLE EMERGENCY LIGHT  
AN EXCELLENT SPOTLIGHT  
A VALUABLE AUXILIARY LIGHT  
IN  
MAJOR SURGERY**

*ALL of that and more is the new  
SCIALYTIC Type H combined  
Operating and Emergency Unit.*

**E**QUIPPED with its special automatic charging storage battery system, portable, ready at all times for emergency use in case of power failure, yet at the same time performing useful service every day in the operating room, the Type H SCIALYTIC is a necessity in every up-to-date Hospital and physician's office.

**O**VER 5000 HOSPITALS now enjoy the advantages of SCIALYTIC illumination — the scientifically correct principle of operating lighting.

*Send for Booklet No. 6*

**SCIALYTIC CORPORATION  
OF AMERICA**



lights, radiators, bumpers, crankshaft bearings, piston pins and other parts, marine hardware and fittings, and even cigar lighters, belt buckles and vanity cases. Other examples are parts of manufacturing machinery receiving tremendous wear and used in the oil, textile, rubber tool and other industries. An interesting use is for the reflectors in acetylene lamps, which are soon dimmed by fumes unless they are chromium plated.

The wide diversity of chromium plated products reveals the reason why this lustrous surface covering is widely preferred. In the first place it makes a beautiful finish, and one that requires no polishing, but simply wiping. In the second place, chromium plating provides a durable and impervious metal surface. It ranks next to the diamond in hardness. It does not tarnish or stain. It is nine times as hard as nickel, five times as hard as the best steel. It does not peel, chip, check or blister and is not affected by sterilizing solutions or heat up to 600° F. It melts only at 2,700° F. and withstands oxidation up to 2,100° F. It is not affected by organic acids, and by only two mineral acids, hydrochloric and sulphuric, the latter but slightly.

Many hospitals have tried the experiment of having old surgical instruments reconditioned and chromium plated.

**Unbreakable Flower Vase Rivals  
Polished Marble in Beauty**

At the suggestion of several hospital executives, a unique flower vase designed particularly for hospital use was put on the market early last Fall. This vase fills the existent need for an unbreakable flower vase which can take the place of its more fragile predecessors and by its use in hospitals and kindred institutions reduce the nerve racking crash of breaking crockery and glass.

The vase at present is being manufactured of the same material that constitutes the manufacturer's rubber tile

*The rubber vase illustrated is attractive both in design and color and, of course, is indestructible.*



floors. Made from ¼-inch reinforced rubber, it measures 9½ inches in height and has a 3½-inch bottom and a 4½-inch top. The vase is steady on its base and exceedingly sturdy. A process of vulcanization does away with unsightly seams and makes the triple weight bottom an inseparable part of the vase, thus eliminating all chance of leakage.

Hospital supply houses are supplying these vases in a variety of harmonious color combinations that are rivals of polished marble for sheer beauty of striation. Their glossy finish does not dull with use, and this feature together with their durable characteristics makes them highly practical for institutional use.